United Nations A/HRC/32/32

General Assembly

Distr.: General
4 April 2016

Original: English

Human Rights Council
Thirty-second session
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Prepared pursuant to Council resolution 24/6, the report focuses on the right of adolescents to the enjoyment of the highest attainable standard of physical and mental health and on the imperative to implement measures necessary to guarantee optimum health and development in accordance with the unique nature of adolescence.

In the report, the Special Rapporteur elaborates on mental health, the rights to sexual and reproductive health, and substance use and drug control, in view of the particular challenges they pose in balancing adolescents' emerging autonomy with their right to protection.

GE.16-05387(E)

Please recycle

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Contents

		Page
I.	Introduction	3
II.	Understanding adolescence and its implications for the right to health	4
	A. A period of transition	4
	B. Challenges to the right to health for adolescents	5
	C. Opportunities for realizing the right to health	6
III.	Right to health in adolescence	7
	A. Understanding the right to health	7
	B. Health care and other health-related services essential for adolescent health	7
	C. Underlying and social determinants of health	8
	D. Right to non-discrimination	11
	E. Participation	11
	F. Accountability	13
IV.	Promotion of emotional well-being and mental health	14
	A. Nature and prevalence of mental health problems in adolescence	14
	B. Promoting effective mental health services	15
V.	Adolescents' rights to sexual and reproductive health	17
	A. Nature of and challenges associated with sexual and reproductive health rights	17
	B. Providing effective sexual and reproductive health services for adolescents	18
VI.	Adolescents, substance use and drug control	20
	A. Nature of and problems associated with substance use in adolescence	20
	B. Providing appropriate services to address adolescent substance use	21
VII.	Conclusions and recommendations	22

I. Introduction

1. Adolescence (10-19 years of age) is a life stage when inequities become more sharply differentiated in terms of access to services, life decisions and future trajectories. Foundations laid down during adolescence, in terms of emotional security, health, education, skills, resilience and the understanding of rights will have profound implications for the social, economic and political development of adolescents. The costs of failing adolescents are high, which is why a powerful case exists for paying greater attention to the right of adolescents to the highest attainable standard of health and development.

2. There is a growing focus on adolescence within the international health and development community, as reflected, most notably, in the *Global Strategy on Women's, Children's and Adolescents Health 2016-2030*. These are important and welcome commitments that now need to be translated into action on the ground.

3. The population of adolescents globally is estimated to be over 1.2 billion. 88 per cent of whom live in developing countries.[1] Adolescents represent 18 per cent of the world's population. Although adolescence is inherently characterized by relatively low mortality compared to other age groups, it is associated with emerging and complex risk factors, resulting in patterns of behaviour that affect long-term morbidity and mortality.[2] Likewise, adolescents are one of the groups that existing health services serve least well.[3]

4. It is estimated that 1.3 million adolescents died in 2012 from preventable or treatable causes.[4] Road traffic accidents, suicide and homicide, violence and war, drowning and fire-related incidents account for about 40 per cent of all deaths among youth (people aged between 15 and 24 years).[5] A small percentage of adolescents suffer from life-limiting and sometimes terminal illness, of which a majority are estimated to have no access to palliative care.[6]

5. Lack of access to safe reproductive health services and information contributes to adolescent girls among the most at risk of dying or suffering from serious or lifelong injuries associated with early pregnancies and childbirth. The lack of effective adolescent mental health policies and services leads to significant failures in emotional and social development, including violence against and among adolescents. Nearly all these risks are preventable, with outcomes grounded in physical and social environments and frequently mediated by their behaviours.

6. The rate and breadth of developmental change during adolescence is second only to that experienced in early childhood.[7] While investments during the past 20 years have resulted in enormous gains for children in the early years,[8] far less recognition has been

[1] United Nations, *World Population Prospects: The 2010 Revision* (2011).

[2] World Health Organization (WHO), *World Health Statistics 2014*.

[3] WHO, *Health for the World's Adolescents*. Available from http://apps.who.int/adolescent/second-decade/files/1612_MNCAH_HWA_Executive_Summary.pdf.

[4] WHO, "Adolescents: health risks and solutions", factsheet No. 345 (2014).

[5] George Patton and others, "Global patterns of mortality in young people: a systematic analysis of population health data", *The Lancet*, vol. 374 (2009), pp. 881-892.

[6] Stephen Connor and others, "Assessment of the need for palliative care for children in South Africa", *International Journal of Palliative Nursing*, vol. 20, No. 3 (March 2014), pp. 130-134; and WHO and the World Palliative Care Alliance, *Global Atlas of Palliative Care at End of Life* (2014), p. 19.

[7] R.M. Viner and others, "Adolescence and the social determinants of health", *The Lancet*, vol. 379, No. 9826 (April 2012), pp. 1641-1652.

[8] A/70/213.

afforded by policymakers to the implications of development in the second decade of life. Over the past 50 years, health has improved far less among adolescents than it has among young children.[9]

7. While there are many health issues of concern during adolescence, in the present report the Special Rapporteur focuses on mental health, substance use and drug control, and the rights to sexual and reproductive health, in view of the particular challenges they pose in balancing adolescents' emerging autonomy with their right to protection. Using the right-to-health framework, the Special Rapporteur underlines the importance of valuing adolescents' strengths and engaging with them as partners in informing and shaping the measures needed to realize the right to health and the optimum development of adolescents.

8. The Special Rapporteur recognizes the heterogeneity of adolescence and that definitions vary by country and region. However, to promote consistency and facilitate the measurement of adolescent health, this report adopts the definition of the World Health Organization, which views adolescents as persons between the ages of 10 and 19 years (until the twentieth birthday).[10]

II. Understanding adolescence and its implications for the right to health

A. A period of transition

9. Adolescence is a life stage of intrinsic value, not merely a transition between childhood and adulthood. It is a critical developmental stage characterized by growing cognitive abilities and emotional competencies, during which the brain has substantial neural plasticity.[11] The physical, mental and social potential established during the second decade contributes to enhanced intellectual ability and emotional functioning throughout adulthood.[12]

10. Adolescent health is the result of interactions between early childhood development and the specific biological and social role changes that accompany puberty, shaped by social determinants and by risk and protective factors that affect the uptake of health-related behaviours.[13] While adolescents themselves have the capacity to contribute to their own health and well-being, they can only achieve this goal if States respect and protect their rights and provide them with access to the necessary conditions, services and information.

11. Adolescence is a period of development towards increasing capacity for independent decision-making, moving away from the protective environments associated with earlier childhood. It is accompanied by greater experimentation, risk-taking and impulsivity and by the increased influence of the peer group. These behaviours contribute to building resilience, character and self-confidence and to the exploration and understanding of boundaries, and reflect the gradual adjustment from protection towards autonomy. Accordingly, while adolescents under 18 years of age continue to be entitled to protection from violence, abuse and exploitation, as well as to consideration of their best interests,

[9] Susan Sawyer and others, "Adolescence: a foundation for future health", *The Lancet*, vol. 379, No. 9826 (April 2012), pp. 1630-1640.

[10] See www.who.int/maternal_child_adolescent/topics/adolescence/en/ and www.who.int/maternal_child_adolescent/documents/fth_adh_98_18/en/.

[11] Susan Sawyer and others, "Adolescence: a foundation for future health".

[12] WHO, *Health for the World's Adolescents*.

[13] Susan Sawyer and others, "Adolescence: a foundation for future health" (abstract).

under the Convention on the Rights of the Child, the nature of those protections and their application must reflect the emerging competencies acquired throughout adolescence.

12. The transition towards adulthood is characterized by the changing nature of relationships. Across cultures, adolescents begin to attach far greater significance to and are increasingly influenced by their peer group and less by family and caregivers.[14] Adolescents also begin to explore their sexuality, sexual orientation and gender identity. There is considerable diversity in combinations of gender identities, expression and sexual orientation, irrespective of whether such diversity is culturally accepted.[15] It is increasingly clear that sexual orientation and gender identity derive from a complex interplay of biological, genetic and social factors and that individuals have little or no choice in its determination.[16]

13. Supporting adolescents to navigate successfully the challenging path towards healthy emotional, psychosocial, physical and sexual development requires recognition of their rights to information, freedom of expression and association, protection from all forms of violence, safety, bodily integrity and family life, and respect for their dignity and evolving capacities.

B. Challenges to the right to health for adolescents

14. Although opportunities for adolescents in many parts of the world have improved in recent years, the second decade of life is associated with exposure to increasing risks to the right to health, including violence, abuse, sexual or economic exploitation, trafficking, harmful traditional practices, migration, radicalization, recruitment into gangs or militias, self-harm, substance use and dependence and obesity. Gender inequalities become more significant as, for example, girls become exposed to child marriage, sexual violence and lower levels of enrolment in secondary education. The world in which adolescents live poses profound challenges, including poverty and inequality, climate change and environmental degradation, urbanization and migration, radical changes in employment potential, aging societies, rising health-care costs and escalating humanitarian and security crises.[17]

15. States policies towards adolescents are too often characterized by targeted or punitive interventions aimed at addressing problems such as juvenile delinquency and violence, as well as perceived challenges, including substance use and sexual activity; too little attention is typically paid to building positive environments in which adolescents can thrive. Punitive and excessively biomedical interventions ignore the powerful social and economic determinants influencing adolescent behaviour, opportunities and well-being. Stigmatizing, demonizing and discriminating against adolescents by, for example, criminalizing or pathologizing their behaviours and diversities, negatively affects their socially perceived roles, self-esteem, well-being and sense of empowerment. These approaches fail adolescents, their holistic development and their right to health.

16. One-size-fits-all policies designed for children or youth often fail to address adolescents, particularly 10-14 year-olds. Lack of awareness or understanding of their unique health needs can render adolescents invisible. Adolescents face multiple barriers to

[14] Clea McNeely and Krishna Bose, "Adolescent social and emotional development : a developmental science perspective on adolescent human rights", in *Human Rights and Adolescence*, Jacqueline Bhabha, ed. (2014).

[15] Ibid.

[16] See www.apa.org/topics/lgbt/orientation.aspx.

[17] UNICEF, *The State of the World's Children 2011: Adolescence — An Age of Opportunity* (2011).

health services, including the following: restrictive laws and policies; unavailability of contraception or safe abortions; inaccessible services owing to lack of information, distance or cost; failure to ensure privacy and confidentiality; parental consent or notification requirements; provision of services in a manner that is disrespectful, hostile, judgemental or lacking sympathy; and discrimination against particular groups of adolescents, including those with disabilities, those living and working on the streets or in the sex trade and those from historically marginalized groups.[18] States have positive human rights obligations to guarantee adolescents' rights and meaningfully engage with them in identifying their needs and priorities.

17. Rapid globalization and associated social and cultural changes, reinforced by the digital world, mean that many adolescents inhabit a world very different from that of the adults around them in relation to information, the speed of change, social norms, risks, aspirations and opportunities. While these rapidly changing environments offer important opportunities for adolescents, they can also pose significant challenges to their rights, for example to privacy, informed consent and freedom from exploitation, with significant implications, in particular for their mental health and well-being. Furthermore, the speed of change can inhibit intergenerational understanding, challenging the capacity of parents and other caregivers to provide the guidance necessary to protect and promote adolescents' right to health.

18. The lack of data disaggregated by age, sex and disability poses one of the biggest challenges to promoting adolescent rights.[19] Without adequate data, States lack evidence to inform health policy, identify gaps and support the allocation of appropriate resources.

C. Opportunities for realizing the right to health

19. Adolescents are actors for social change, and are able to bring dynamism, flexibility, creativity and energy towards the realization of their own and others' rights to health. States should adopt a human rights framework for adolescent health guided by the recognition of their strengths, capacities and contributions, while also addressing the impact of social determinants of health. Respecting and engaging with adolescents and treating them as a resource contributes to building foundations for emotional security, health, education and the skills needed for the full and effective realization of the right to health.

20. Adolescents have the right to play an increasingly important role in the determination of their own health care. Respect and recognition of their capacities is intrinsic to the enhancement of positive health outcomes. Forging partnerships with adolescents is the key to shaping an environment that enables the realization of their right to health.

21. In particular, adolescents' leading role in using and shaping new communications technologies places them in a position to build and utilize networks to promote their right to health, for example through information dissemination, data gathering, health campaign design, health education, peer-to-peer education and counselling and conflict mediation. A number of e-health and web-based interventions and mobile applications can provide information, increase access to care, engage adolescents in treatment and initiate aftercare. These skills and capacities mean that adolescents are uniquely positioned to contribute to the attainment of the Sustainable Development Goals, in particular Goal 3, as well as to

[18] WHO, *Making Health Services Adolescent Friendly* (2012).
[19] UNICEF, *The State of the World's Children 2011*.

monitoring and holding Governments to account on the commitments made (General Assembly resolution 70/1).

III. Right to health in adolescence

A. Understanding the right to health

22. The Convention on the Rights of the Child provides a comprehensive normative and legally binding framework to address the right to health of adolescents under the age of 18, while other treaties, such as the International Covenant on Economic, Social and Cultural Rights, provide a framework relevant for all adolescents, including those aged 18 and 19.

23. Further group-specific protections are found in other human rights treaties, but the Committee on the Rights of the Child has been at the forefront of efforts to apply the right to health in the context of adolescents, notably in its general comment No. 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child and general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health.

24. The right to health of adolescents is closely related to other human rights included in these treaties, such as the rights of the child to healthy development, education, play and recreation, social security and privacy, and to being free from torture, all forms of violence and economic, sexual and other forms of exploitation. The right to health is also inextricably linked to non-discrimination and equality, participation and accountability. Adolescent health and development need to be promoted in the context of a holistic and comprehensive approach to the wider determinants affecting the opportunities, choices and consequent development of adolescents.

25. The right to health provides a valuable normative framework grounded in a commitment to promote the best interests of adolescents while acknowledging their evolving capacities to take increasing levels of responsibility for their own health care. It also places a legal obligation on States to progressively realize the highest attainable standard of health of adolescents; eliminate discrimination and inequalities that obstruct equitable enjoyment of the right to health; ensure the participation of adolescents in relevant efforts; devote maximum available resources to the right to health of children; develop suitable laws and policies, including a comprehensive national health plan that addresses adolescents' right to health; and ensure accountability, including effective remedies.

26. The private sector is a significant provider of health care in many countries and plays a major role in the development and refinement of drugs and health-related products and technology. States should ensure that benefits accrue to all adolescents.[20]

B. Health care and other health-related services essential for adolescent health

27. States must ensure that health systems, including health-care services, in cooperation with other relevant services, such as social, child protection and education services, are responsive to the right to health of adolescents. They should address the full spectrum of adolescent health and development, including health promotion, sexual and reproductive

[20] Committee on the Rights of the Child general comment No. 15, para. 42.

health, mental health, palliative care, unintentional and intentional injuries, violence, and health-compromising behaviours that may begin during adolescence.

28. Rather than only setting up separate interventions and facilities for adolescents, efforts should be made to ensure that adolescents receive adequate attention in all policies, strategies and programmes that are relevant to them. Health systems should be designed and services should be delivered in a way that respects the right to health and other related rights of adolescents, in accordance with their evolving capacities. This can only be achieved by guaranteeing the right of adolescents to be heard and to contribute to the planning, implementation, monitoring and evaluation of services.

29. The right to health gives rise to an obligation of States to ensure the availability, accessibility, acceptability and quality of health services, goods and facilities. States must ensure that sufficient health facilities, goods, services and programmes are available to meet the needs of adolescents, especially the most marginalized.

30. Services, goods and facilities must be accessible to all adolescents without discrimination on any grounds. This includes access to information on their health, as well on the nature, availability, location, costs and timing of services. Services must be physically accessible, including to adolescents in remote or rural communities and adolescents with disabilities, and be located in spaces that provide adolescents with confidence that their specific health-care needs will be met.

31. Services and goods must be affordable, considering that adolescents rarely have financial means or autonomy, and accessible, directly and without parental support. In practice, it should be recalled that user fees can obstruct access to services.

32. States should develop a core package of interventions for adolescents, including to sexual and reproductive health services, that are available free of charge. Services must be designed and delivered in a manner consistent with the evolving capacities, developmental needs and the best interests of adolescents. They must respect adolescents' right to privacy and confidentiality, address different cultural needs and expectations and comply with ethical standards. Services must be sensitive to gender and lesbian, gay, bisexual, transgender and intersex status, they must be non-judgemental regarding adolescents' personal characteristics, lifestyle choices or life circumstances and they must treat all adolescents with dignity and respect, consistent with their status as rights holders.

33. All health-related services must be appropriate and of good quality, with skilled personnel who have been adequately trained, in particular on adolescents' right to health. Equipment and drugs must be appropriate for adolescents and regular assessments of the quality of health-care services undertaken.

34. The health sector should take the lead in development plans for adolescents' right to health. However, intersectoral collaboration is vital, including among the education and social protection sectors, and right-to-health considerations must be integrated into relevant policies and strategies.

C. Underlying and social determinants of health

35. The right to health is not only a right to health care, but a right to underlying and social determinants of health. Social determinants are the conditions in which people are born, grow, live, work and age that influence their health. The evidence overwhelmingly shows that the strongest determinants of adolescent health worldwide are structural factors

such as national wealth, income inequality, gender systems and access to education.[21] Additional determinants include social norms, laws and policies and the physical environment, as well as the online social media environment, which plays an increasingly influential role in adolescents' lives.

36. States must take legal, policy and other measures to address the underlying and social determinants of adolescent health, including: road and environmental safety; racial prejudice; access to education; persistence of forced and early marriage; corporal punishment; social, economic, political, cultural and legal barriers to health services, including sexual and reproductive health services; inadequate social protection; institutionalization; punitive drug laws; absence of comprehensive sexuality education; criminalization of exposure, non-disclosure of HIV status and transmission of HIV; criminalization of same-sex relationships; and lax legal frameworks governing the sale of tobacco, alcohol and fast foods.

37. Measures to address the right to health should be holistic and integrated, go beyond the provision of health services and be underpinned by cross-departmental commitment. States should take account of and respond to the particular challenges faced by different groups, such as younger and older adolescents, males, females and lesbian, gay, bisexual, transgender and intersex persons.

Right to protection from all forms of violence

38. Exposure to violence increases during adolescence, to the point that it is a primary cause of mortality and morbidity in the second decade.[22] Violence occurs in the family, in the community, at work or at the hands of State actors.

39. Adolescent girls, adolescents with disabilities, lesbian, gay, bisexual, transgender and intersex adolescents, adolescents living in institutions and adolescents from communities with a proliferation of unregulated weapons or experiencing armed conflict are among those particularly vulnerable to violence. The risks for girls include, for example, exposure to sexual violence and exploitation, forced and early marriage, honour killings and abusive practices often carried out in health-care settings, such as forced sterilization and forced abortion for girls with disabilities, and forced virginity testing.[23]

40. Violence in intimate relationships among adolescents is also common, resulting in both immediate and potential long-term consequences for their physical, mental and social health. In addition to its immediate health consequences, the trauma of violence perpetrated by an intimate partner can lead to long-term physical injuries, to both immediate and delayed-onset health problems and to experiences of repeated revictimization.[24]

41. Lesbian, bisexual and transgender youth are at risk of "punitive" rape on the basis of their sexual orientation or gender identity. Adolescents suffer disproportionately from the effects of gun violence and significant numbers of adolescents face serious harm or death as a consequence of armed conflict.

42. The focus in the Sustainable Development Goals on tackling violence against women and girls is welcome. However, significant levels of violence are also experienced

[21] R.M. Viner and others, "Adolescence and the social determinants of health".

[22] WHO, *Health for the World's Adolescents*.

[23] See joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices.

[24] C.C. Pallitto and V. Murillo, "Childhood abuse as a risk factor for adolescent pregnancy in El Salvador", *Journal of Adolescent Health*, vol. 42, No. 6 (2008), pp. 580-586.

by adolescent boys. Boys caught up in violent crime are often exposed to harsh punitive responses by States that create a downward spiral of increasing violence with profound detriment to their physical and mental health and well-being.

43. In line with the Convention on the Rights of the Child and the recommendations of the Committee on the Rights of the Child, States must introduce measures addressing the specific forms of violence faced by adolescents.[25] Recognizing the right of adolescents to exercise increasing levels of responsibility should not obviate States' obligations to guarantee them protection.

44. Rights to protection and increasing participation are mutually reinforcing. Guaranteeing adolescents the right to be heard, to challenge rights violations and to seek redress empowers them to exercise agency in their own protection.[26] Failure to do so will condemn millions globally to continuing and extreme violations of their rights.

45. The right to protection extends to violence in the digital environment. With growing use of social media and online activity, adolescents are increasingly vulnerable to cyberbullying, which is associated with a wide range of mental, psychosocial, cognitive, educational and health problems, including depression and suicide, as well as other poor coping responses such as problems with alcohol and other drug use. However, it is neither appropriate nor possible to seek to restrict adolescents' access to the digital environment. Therefore, States should fulfil their obligations through the adoption of holistic strategies aimed at enhancing adolescents' capacities to protect themselves from online harm, strengthening legislation and law enforcement mechanisms to tackle online abuse, including cross-border abuse, combating impunity and training parents and professionals who work with children.

Family life

46. The family, in its diverse forms and arrangements, refers to the essential environment for the well-being, protection and development of children and adolescents. The recognition of diverse family forms is necessary to ensure the protection and promotion of the rights of all of children and adolescents, without discrimination of any sort.

47. Safe and supportive families are crucial to helping adolescents develop to their full potential and attain the best health into adulthood. Therefore, support of the family environment is very important for the physical and mental health of children and adolescents. States should develop policies and services that support families and strengthen their parenting competencies so that all children can grow in healthy family environments.

48. Policies designed to protect families and family values should avoid measures that undermine the human rights of individual family members, including women, adolescents and younger children.[27] Such approaches can be detrimental as they may, in the name of traditional values, tolerate or condone violence, reinforce unequal power relations within family settings and, therefore, deprive adolescents from the opportunity to exercise their basic rights.

49. States should take specific measures to ensure that adolescents with disabilities enjoy their right to family life and are not removed from their families against their will.

[25] See articles 19, 37 and 39 of the Convention on the Rights of the Child and Committee on the Rights of the Child general comment No. 13 (2011) on the right of the child to freedom from all forms of violence.

[26] Committee on the Rights of the Child general comment No. 13, para. 63.

[27] See A/HRC/31/37, para. 23.

States should ensure that information, training and support are provided to parents to enable them to help their adolescent children attain the highest attainable standard of health.

D. Right to non-discrimination

50. The right to non-discrimination is fundamental to realizing adolescents' right to health. Discrimination encompasses any distinction, exclusion or restriction that has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.[28]

51. Adolescence itself can be a basis for discrimination, with many adolescents treated as dangerous or hostile, incompetent to make decisions, incarcerated, exploited or exposed to violence as a direct consequence of their age. Health-care providers may perpetuate discrimination against adolescents when they deny them health services or contraceptive supplies or treat them poorly, which can make adolescents reluctant to seek the health-care they need. Adolescents belonging to marginalized groups or sectors, such as girls, racial or ethnic minorities, indigenous populations, lesbian, gay, bisexual, transgender and intersex adolescents, refugees and adolescents with disabilities, face a heightened risk of exclusion.

52. To achieve substantive equality, States must take special measures in order to diminish or eliminate conditions that cause discrimination"[29] by introducing comprehensive legislation and policies, as well as affirmative action measures, to diminish or eliminate structural barriers and historic conditions that result in direct or indirect discrimination against any group of adolescents on any grounds.

E. Participation

53. International human rights standards require the free, active and meaningful participation of people in decisions that affect their lives.[30] In particular, States' obligations under article 12 of the International Covenant on Economic, Social and Cultural Rights require that the right of individuals and groups to participate in decision-making processes affecting their health and development must be an integral component of any relevant policy, programme or strategy.

Right of adolescents to be heard and regarded as the subjects of rights

54. Children, including adolescents, lack the full autonomy of adults while being subjects of rights. Article 12 of the Convention on the Rights of the Child addresses the legal and social status of children, recognizing their capacity to form their own views and to express them freely in all matters affecting them and giving them due weight in accordance with age and maturity.[31]

55. This has been broadly conceptualized as the right to and principle of participation, and is central to the realization of adolescents' right to health, both in individual matters relating to their own health care and in wider issues such as the design and development of

[28] See Human Rights Committee general comment No. 18 (1994) on non-discrimination.

[29] See Committee on the Rights of the Child general comments No. 15, para. 12, and No. 5 (2003) on general measures of implementation of the Convention on the Rights of the Child, para. 12.

[30] Universal Declaration of Human Rights, art. 21, and the International Covenant on Civil and Political Rights, art. 25.

[31] See Committee on the Rights of the Child general comment No. 12 (2009) on the right of the child to be heard.

health-related services. It implies a fundamental shift in the traditional status of the child as a passive recipient of adult decisions and interventions.

36. In order to ensure the relevance and efficacy of interventions, adolescents' experiences, concerns, knowledge and creativity should be utilized in the development, implementation and monitoring of relevant legislation, policies, services and programmes affecting their right to health and development at the school, community, local and national levels.[32] Consultative mechanisms alone are insufficient to fulfil the right to be heard and to be taken seriously. Adolescents must be afforded safe spaces with opportunities to identify for themselves issues of most concern to them and to enable them to act on those concerns. Particular attention should be paid to adolescents with disabilities, who must be provided with disability and age-appropriate assistance to realize this right.[33]

Right to respect evolving capacities

57. During adolescence, the right to be heard and to be taken seriously transitions into the right to make autonomous decisions about one's health care and treatment. The concept of children's evolving capacities is an enabling principle addressing the process of maturation and learning through which children progressively acquire competencies and understanding.[34]

58. Not only is adolescence a period of considerably enhanced cognitive development, it is also associated with greater self- and social awareness, and the ability to grapple with complexity and to take into consideration the perspectives of others.[35] These developments have profound implications for adolescents' capacities to take increasing levels of responsibility for decision-making in respect of the right to health.

59. However, all too often States continue to deny adolescents the right to make autonomous and confidential decisions with regard to accessing health services by requiring parental notification or consent. These restrictions often make adolescents reluctant to access needed services so as to avoid seeking parental consent, which may result in rejection, stigmatization, hostility or even violence.

60. States are urged to consider the introduction of a legal presumption of competence that an adolescent seeking preventive or time-sensitive health goods and services, including for sexual and reproductive health, has the requisite capacity to access such goods and services. Where minimum ages of consent exist, as the Committee on the Rights of the Child has argued, any adolescent below that age and able to demonstrate sufficient understanding should be entitled to give or refuse consent. At a minimum, States should ensure a minimum age well below 18 years at which adolescents have the right to consent to or refuse services without mandatory authorization or notification of parent, guardian, spouse or intimate partner. The right to counselling and advice is distinct from the right to give medical consent and should not be subject to any age limit.[36]

---

[32] Ibid.

[33] Convention on the Rights of Persons with Disabilities, art. 7 (3).

[34] See Convention on the Rights of the Child, art.5, and Committee on the Rights of the Child general comment No. 7 (2006) on implementing child rights in early childhood.

[35] Sarah-Jayne Blakemore and S. Choudhury, "Development of the adolescent brain: implications for executive function and social cognition", *Journal of Child Psychology and Psychiatry*, vol. 47, Nos. 3-4 (2006), pp. 296-312; and Sarah-Jayne Blakemore and Katheryn L. Mills, "Is adolescence a sensitive period for sociocultural processing?", *Annual Review of Psychology*, vol. 65 (2014), pp. 187-207.

[36] Committee on the Rights of the Child general comment No. 12.

61. Particular regard must be afforded to the barriers faced by adolescents with disabilities, as their views should be given due weight in accordance with age and maturity on an equal basis with others and as they must be provided with opportunities for supported decision-making.[37]

F. Accountability

62. Accountability, including its constituent components monitoring, review and redress, is essential if the right to health is to be more than an aspiration.[38] Accountability reveals where progress has been made and where it has not been made, allows duty bearers to explain what they have done and make adjustments, and provides an opportunity for rights holders, including adolescents, to engage with duty bearers in the promotion and protection of their rights and to seek redress where violations have occurred.[39]

63. The commitment expressed in the *Global Strategy on Women's, Children's and Adolescents' Health 2016-2030* to improve national and global accountability, including for adolescent health, is welcome, as is the broader commitment to accountability in the Sustainable Development Goals. In this connection, States should ensure the quality and timely collection of appropriately disaggregated data and that laws, policies and programmes concerning adolescent health are transparently and regularly reviewed. National assessments or public inquiries into adolescents' right to health are welcome and could be conducted by national institutions.

64. Adolescents, together with other key civil society stakeholders, should play an active role in accountability. They should be actively involved in the determination of indicators at the national and local levels that reflect the issues they consider to be of critical importance in realizing the right to health.

65. To achieve this, all relevant policies should be devised, and periodically reviewed, on the basis of a transparent process and with the participation of adolescents, and should include right to health indicators and benchmarks.[40] Indicators should be disaggregated on suitable grounds, including those identified in the Sustainable Development Goals, namely age, income, gender, race, ethnicity, migratory status, disability and geographic location, in order to monitor the health status of marginalized groups and sectors of adolescents (see target 17.18). Adolescents and other relevant civil society actors should also be actively involved in review processes.

66. States should ensure adolescents have access to effective remedies to adjudicate violations of their right to health, through the provision of supportive, child-friendly redress mechanisms with the authority to adjudicate claims made by adolescents and filed on their behalf, as well as access to subsidized or free legal services and other appropriate assistance (see A/HRC/25/35). Furthermore, States should put in place preventive remedies where adolescents can challenge denials of access to health services.[41]

---

[37] Committee on the Rights of Persons with Disabilities general comment No. 1 (2014) on equal recognition before the law.

[38] WHO Commission on Information and Accountability, *Keeping Promises: Measuring Results* (2011).

[39] Helen Potts, *Accountability and the Right to the Highest Attainable Standard of Health* (2008).

[40] Committee on Economic, Social and Cultural Rights general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 43 (f).

[41] See *LC v. Peru*; *P&S v. Poland*.

IV. Promotion of emotional well-being and mental health

A. Nature and prevalence of mental health problems in adolescence

67. Globally, it is estimated that approximately 20 per cent of 14-24 year olds experience a mental health condition each year.[42] The transition from childhood to adulthood is a period of heightened vulnerability (half of all lifetime mental disorders appear by the age of 14 years) caused to a significant extent by the physical, psychological and emotional changes arising during this period. Research indicates that depression is the primary cause of illness and disability among adolescents and suicide is the third leading cause of death.[43]

68. Poor mental health can affect the health and development of adolescents more generally and is associated with many damaging health and social outcomes, such as substance use, the inability to form relationships, dropping out of school or academic underperformance and delinquent behaviours, together with increased likelihood of poverty and poorer employment opportunities.[44]

69. The risk of experiencing mental ill-health is heightened by poverty and by adverse childhood events, including, for example, sexual and emotional abuse, bullying and parental loss. Adolescents in post-conflict or disaster settings or who are homeless and street-involved, orphaned, lesbian, gay, bisexual, transgender and intersex or involved with the juvenile justice system are also at greater risk. Adolescents in the juvenile justice system suffer substantially higher rates of mental health conditions than those in the general population, with an estimated 70 per cent having at least one diagnosable mental health condition.[45]

70. The international human rights framework establishes the clear duty of States to promote adolescents' mental health and emotional well-being, provide appropriate mental health treatment and care and ensure that mental health laws fully recognize the rights of those with mental illness.[46] Target 3.4 of the Sustainable Development Goals is to reduce by one third premature mortality from non-communicable diseases through prevention, treatment and the promotion of mental health and well-being. That target must be applied fully to adolescents.

71. Despite these obligations and commitments, there is a worrying lack of recognition or awareness of the nature and scale of mental health problems among adolescents in many countries. Evidence indicates that many adolescents consider emotional well-being to be the most important health problem they face and would like more access to quality mental health care.[47]

72. The nature of adolescents' mental health needs differs from that of adults and requires targeted services. However, a national health system of well-functioning, effective

---

[42] Vikram Patel, Benedetto Saraceno and Arthur Kleinman, "Beyond evidence: the moral case for international mental health", *American Journal of Psychiatry*, vol. 163, No. 8 (2006), pp. 1312-1315; and UNICEF, *The State of the World's Children 2012: Children in an Urban World* (2012).

[43] WHO, "Adolescents: health risks and solutions", factsheet No. 345.

[44] United Nations, *Mental Health Matters: Social Inclusion of Youth with Mental Health Conditions*, (2014).

[45] Ibid.

[46] Convention on the Rights of the Child , arts. 24 (1) and (2) (b) and 6; Committee on Economic, Social and Cultural Rights general comment No. 14; and E/1995/22-E/C.12/1994/20.

[47] WHO, *Health for the World's Adolescents*.

and adolescent-friendly services remains the exception rather than the rule. Less than one third of low- and middle-income countries have a designated youth mental health entity and most lack youth-focused mental health policies.[48] Where they do exist, they often fail to meet quality standards and may even be harmful to the health and development of adolescents. Adolescents may be detained for a long time in overcrowded, in-patient facilities where little attempt is made at rehabilitation or social integration.[49] These approaches violate adolescents' human rights and worsen, rather than ameliorate, mental health conditions.

73. Public and self-stigmatizing attitudes towards mental illness, concerns about confidentiality and lack of general understanding all serve as barriers to getting help, particularly among adolescents, a problem compounded by the lack of quality mental health services in low- and middle-income countries.[50] For adolescents, the attitude of service providers is more important than their technical expertise. Adolescents who seek services often experience negative or hostile responses from health-care providers, leading to a further reluctance to access help. Same-sex attraction is still considered by doctors in many countries to be a mental disorder.[51] Lesbian, gay and bisexual adolescents may be subjected to harmful therapeutic interventions intended to eliminate or suppress their sexual instincts. Such therapies have been deemed unethical, unscientific, ineffective and, in some instances, tantamount to torture.[52]

B. Promoting effective mental health services

74. Prevention of mental health problems and promotion of mental well-being in adolescence should be a central part of national health policies. Action plans should include programmes for evidence-based interventions that are well-funded and monitored and that aim to reinforce protective factors within adolescents, their families and communities.

75. Accordingly, the focus should be on building resilience, supporting parents, stimulating adequate help-seeking behaviours, creating positive peer groups and school environments, ensuring opportunities for influence and decision-making, increasing empowerment and emotional literacy. Furthermore, such programmes can also address risk behaviours such as bullying, suicidal behaviour, domestic violence and substance use.

76. Models based on over-medicalization and institutionalization should be abandoned and replaced with early interventions and comprehensive community-based multisectoral responses. Adolescent health policies must be developed with the involvement of professionals in the health, education and social welfare sectors, who can provide a flexible network of services, including schools, community outpatient and day care mental health services rooted in the evidence-based biopsychosocial model.[53]

---

[48] United Nations, *Mental Health Matters*.

[49] Vikram Patel and others, "Mental health of young people: a global public-health challenge", *The Lancet*, vol. 369, No. 9569 (2007), pp. 1302-13.

[50] Amelia Gulliver, Kathleen Griffiths and Helen Christensen, "Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review", *BMC psychiatry*, vol. 10, No. 1 (2010), p. 113.

[51] United Nations Development Programme and USAID, "Being LGBT in Asia: China country report" and "Being LGBT in Asia: Cambodia country report".

[52] A/HRC/29/23.

[53] G. Thornicroft and M. Tansella, "The balanced care model for global mental health", *Psychological Medicine*, vol. 43, No. 4 (2013), pp. 849-863.

77. Cost-effective public health and psychosocial interventions, including social protection, psychoeducation, coaching, counselling and psychotherapy, as well as parent training, should be available and accessible to all adolescents in need and their families. Such approaches aim at improving behaviour, holistic development and specific life skills, and reduce the need for medication.[54] Medications and inpatient services may be needed as part of treatment plans in complex cases of mental conditions, but these treatment modalities should be used with caution. Schools are well-placed to promote emotional well-being and mental health and to prevent mental health problems, for example, through classes on mental health literacy.[55]

78. Psychosocial interventions are not a luxury: on the contrary, when used in a manner consistent with adolescents' rights, ethically and on the basis of evidence, they are essential interventions. Indeed, the World Health Assembly, in its resolution 65.4, has noted the increasing evidence of effectiveness and cost-effectiveness of such approaches to promote mental health and prevent mental disorders particularly among adolescents. Furthermore, the Committee on the Rights of the Child has strongly encouraged States to adopt and scale up these interventions, in line with their obligations to promote adolescents' right to health.[56]

79. States should invest in programmes to challenge outdated beliefs and negative attitudes about mental conditions through the dissemination of information. Adolescents of different ages and representing different perspectives should be consulted in the design, development, implementation and monitoring of mental health services. Investments must be made to address gender discrimination in mental health and to reach out to marginalized communities, which are disproportionately vulnerable to mental health problems and experience greater barriers in accessing services.

80. The right to mental health must be underpinned by legal frameworks that are fully compliant with human rights standards, which demand respect for the evolving capacities of adolescents with disabilities and their physical integrity. Adolescents with disabilities are vulnerable to neglect, mental and physical abuse, sexual violence and forced sterilization or contraception while detained in mental health care settings.

81. Accordingly, all institutions should adopt and publish principles and standards of care and establish safe and effective reporting mechanisms and systems for redress in line with international standards.[57] Monitoring mechanisms should be in place to ensure that violations of the rights of adolescents in mental health care settings can be reported and redress sought.

82. The vulnerability of the growing number of adolescents in refugee camps or seeking asylum is worrying. States are reminded of their broad international obligations to protect refugees[58] and ensure necessary assistance in the enjoyment of their rights, including the right to optimum mental health and well-being.

---

[54] Peter Fonagy and others, *What Works for Whom?: A Critical Review of Treatments for Children and Adolescents* (2014).

[55] "A preparatory action related to the creation of an EU network of experts in the field of adapted care for adolescents with mental health problems: final report" (2015).

[56] Committee on the Rights of the Child general comment No. 15.

[57] See www.unicef.org/protection/alternative_care_Guidelines-English.pdf.

[58] Convention on the Rights of the Child, art. 22.

V. Adolescents' rights to sexual and reproductive health

A. Nature of and challenges associated with sexual and reproductive health rights

83. Healthy sexual development requires not only physical maturation, but an understanding of healthy sexual behaviours and a positive sense of sexual well-being. Sexual initiation can be a natural and healthy aspect of adolescence, and adolescents have the right to be provided with the tools and information to navigate sex safely. Sexual activity among adolescents is widespread, although rates vary significantly. Yet, adolescents around the world face significant discrimination and barriers in accessing the information, services and goods needed to protect their sexual and reproductive health, resulting in violations of their right to health.

84. Many adolescents, in particular girls and those identifying as lesbian, gay, bisexual and transgender, are deterred from approaching health professionals in anticipation of a judgemental attitude that results from social norms or laws that stigmatize or criminalize their sexual behaviour. Rights to sexual and reproductive health for many adolescents are further compromised by violence, including sexual and institutional violence, coercion into unwanted sex or marriage, and patriarchal and heteronormative practices and values. This reinforces harmful gender stereotypes and unequal power relations that make it difficult for many adolescent girls to refuse sex or insist on safe and responsible sex practices.

85. The vulnerability of boys to physical and sexual abuse and exploitation should be highlighted, together with the significant barriers they face in accessing sexual and reproductive information and services. Intersex adolescents often experience particular challenges because of irreversible and non-consensual surgeries performed during their early childhood and because of the natural development of their bodies.[59] Discrimination within the family and society, as well as discriminatory attitudes by health providers, can result in the denial of access to health services, while lack of knowledge and awareness within the medical profession further impedes access to quality care.[60]

86. Adolescents with disabilities are frequently subjected to forced medical treatment, including sterilization, abortion and contraception, which can constitute torture or cruel, inhuman or degrading treatment.[61] Girls with disabilities in particular experience alarmingly disproportionate levels of physical and sexual violence, frequently without any means of redress or access to justice.[62] Many health-care providers hold inaccurate, stereotypical views about individuals with disabilities, including assumptions that they are asexual, which serves to deny them access to sexual and reproductive health information, services and goods, as well as comprehensive sexuality education.[63]

87. AIDS is the second most common cause of death among adolescents globally.[64] Worldwide, adolescents in key population groups, including gay and bisexual boys, transgender adolescents, adolescents who exchange sex for money, goods or favours and adolescents who inject drugs, are also at a higher risk of HIV infection. Adolescent girls in

[59] A/70/213.
[60] A/HRC/32/44.
[61] A/HRC/22/53.
[62] A/66/230.
[63] Handicap International and Save the Children, *Out from the Shadows: Sexual Violence against Children with Disabilities* (2011), p. 13.
[64] WHO, *Health for the World's Adolescents*.

high-HIV burden countries are particularly vulnerable, making up 75 per cent of new infections in Africa in 2013,[65] with gender inequality, harmful traditional practices and punitive age of consent laws identified as drivers of the epidemic.[66] These sectors and groups face a disproportionately high risk of experiencing stigma, discrimination, violence, rejection by families, criminalization and other human rights violations when seeking sexual and reproductive health services, including denial of access to health-care services, such as HIV testing, counselling and treatment.

88. Rights to sexual and reproductive health are therefore of critical importance. Sexual health is defined as a "state of physical, emotional, mental and social well-being related to sexuality, not merely the absence of disease, dysfunction or infirmity".[67] Article 24 (2) (f) of the Convention on the Rights of the Child and article 12 (2) of the Convention on the Elimination of All Forms of Discrimination against Women both recognize the right to the provision of family planning education and services, including to adolescents, without discrimination on any grounds.[68] However, United Nations treaty bodies consistently raise concerns relating to the provision of sexual and reproductive health information, services and goods. They have also strongly affirmed that adolescents' sexual and reproductive health implicates a broad range of human rights, including to non-discrimination, freedom from torture or ill-treatment, privacy and education.[69]

B. Providing effective sexual and reproductive health services for adolescents

89. Given the scale of these concerns, target 3.7 of the Sustainable Development Goals, on ensuring universal access to sexual and reproductive health-care services, is welcome. To achieve this target, States will have to adopt a comprehensive gender-sensitive and non-discriminatory sexual and reproductive health policy for all adolescents and to integrate it into national strategies and programmes.[70]

90. These policies must be consistent with the human rights standards and recognize that unequal access by adolescents constitutes discrimination.[71] All adolescents must be guaranteed access to confidential, adolescent-responsive and non-discriminatory sexual and reproductive health information, services and goods, including family planning, modern forms of contraception, counselling, pre-conception care, maternal care, sexually transmitted infections, diagnosis and treatment, and safe abortion.[72] Adolescent sexual and reproductive health services must be welcoming, adolescent-friendly, non-judgemental and guarantee privacy and confidentiality. Health providers should also consider the establishment of dedicated clinic times and alternative locations for adolescents, particularly with regard to sexual and reproductive health services.

---

[65] UNAIDS and the African Union, *Empower Young Women and Adolescent Girls: Fast-Tracking the End of the AIDS Epidemic in Africa* (2015).

[66] E/CN.4/2005/72.

[67] Paul Hunt and Judith Bueno de Mesquita, *The Rights to Sexual and Reproductive Health* (2006).

[68] Committee on the Rights of the Child general comment No. 15.

[69] *K.L. v. Peru*, CCPR/C/DJI/CO/1 and CAT/C/PER/CO/4.

[70] WHO, *Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations* (2014).

[71] Committee on Economic, Social and Cultural Rights general comment No. 20 (2009) on non-discrimination in economic, social and cultural rights.

[72] Committee on the Rights of the Child general comments No. 4 and No. 15.

91. Furthermore, States should introduce measures to raise adolescents' awareness of their rights to sexual and reproductive health and to services and goods at the family, school and community levels. Age-appropriate, comprehensive and inclusive sexuality education, based on scientific evidence and human rights, should be part of the mandatory school curriculum, with special attention given to relationships, sexuality, gender equality and identity and sex characteristics, including non-conforming gender identities, responsible parenthood and sexual behaviour, and preventing early pregnancy and sexually transmitted infections.[73]

92. States are strongly encouraged to decriminalize abortion, in accordance with international human rights norms, and adopt measures to ensure access to legal and safe abortion services. Criminal laws with respect to abortion result in a high number of deaths, poor mental and physical health outcomes, infringement of dignity and amount to violations of the obligations of States to guarantee the right to health of adolescent girls.[74] Furthermore, information about and access to abortion services must be available, accessible and of good quality, without discrimination, at a minimum in the following circumstances: when the life or health of the mother is at risk, when the mother is the victim of rape or incest and if there is severe and fatal foetal impairment. Post-abortion care must be available and accessible to all adolescent girls irrespective of the legal status of abortion.

93. Prevention, care, treatment and support are mutually reinforcing elements in providing a comprehensive and effective response to HIV/AIDS.[75] All adolescents should have access to HIV testing and counselling, and evidence-based HIV prevention and treatment programmes. Health services should offer HIV-related information, testing, sexual and reproductive health services, contraception, condoms and HIV-related care and treatment, including antiretroviral and other medicines, diagnostics and related technologies for the care of HIV/AIDS, related opportunistic infections and other conditions, good nutrition and social, spiritual and psychological support, as well as family, community and home-based care.

94. The Special Rapporteur deplores the imposition of treatments to try to change sexual orientation and gender identity, including forced sex assignment surgeries for intersex youth, forced sterilizations and abortions for girls with disabilities, the use of surgery and hormone therapy to stunt the growth of children with developmental disabilities and remove their reproductive organs, and the pathologizing of transgender identity and same-sex attraction as psychiatric disorders. States should eliminate such practices and to repeal all laws criminalizing or otherwise discriminating against individuals on the basis of their sexual orientation or gender identity and expression.[76] There is a need to reform and update national health information systems to include human rights concepts and variables such as lesbian, gay, bisexual and intersex status.[77]

---

[73] General Assembly resolution 70/137 and UNESCO, *International Technical Guidance on Sexuality Education* (2009).

[74] A/66/254 and A/HRC/32/44.

[75] Committee on the Rights of the Child general comment No. 3 (2003) on HIV/AIDS and the rights of the child.

[76] See A/HRC/22/53; CRC/C/RUS/CO/4-5; CRC/C/GAM/CO/2-3, paras. 29-30; and CRC/C/CHE/CO/2-4, paras. 42-43.

[77] Pan American Health Organization resolutions CD50.R8 and CD52.R6.

VI. Adolescents, substance use and drug control

A. Nature of and problems associated with substance use in adolescence

95. Adolescence is a period of risk-taking and experimentation with greater likelihood of initiation into substance use. Adolescents are at higher risk of drug-related health harms, while substance use initiated in adolescence can more often lead to dependence than during adulthood. The most commonly used substances are alcohol, tobacco and solvents. Illicit drug use, in particular cannabis, is also common and in recent years unregulated novel psychoactive substances have become an important concern.[78]

96. Outside of high-income countries, data relating to adolescent substance use and related health harms are poor. Important differences exist among and within countries, between adolescents and their older counterparts and among groups of adolescents. For example, heavy episodic or binge use, especally of alcohol, is more common among young people.[79] Adolescents' access to services is limited in comparison to adults, for example, being under the legal age of majority can block adolescents from accessing certain services. Those identified at greatest risk of drug-related harms are those who are street-involved, excluded from school, have histories of trauma, family breakdown or abuse, and those living in families coping with drug dependence. Adolescent girls are at a higher risk of certain kinds of harm than boys, including HIV infection due to both sexual transmission and unsafe injecting practices. These factors demand concerted efforts to gather appropriately disaggregated data to better understand patterns of vulnerability so that services can be targeted and properly budgeted.

97. In addition to substance use, there are significant physical and mental health consequences to adolescents' involvement in the production of and trade in substances. Adolescents are involved at all stages of the licit and illicit drug supply chains. With regard to illicit drugs, in addition to sometimes hazardous work, adolescents can be exposed to organized crime, violence and counter-narcotics operations. More research is needed into the adolescent health implications linked to the production of drugs and the violence associated with the criminal market.

98. The harms associated with drug use and involvement in the drug trade cannot be disentangled from State responses. Evidence shows that repressive and punitive responses to drugs have not been effective in reducing drug use or supply[80] and that they have produced negative consequences, including violence and corruption.[81] Criminalization of drug use and personal possession, as well as drug user registries and police violence, drive young people from services, producing a health-deterrent effect. Prevention and education programmes that focus on zero tolerance create an environment where adolescents may be less likely to seek information about harms related to use. Adolescents have lost parents to drug-related violence and to prolonged incarceration for non-violent offences, with significant implications for their mental health.

---

[78] UNODC, *World Drug Report 2015* (United Nations publication, Sales No. E.15.XI.6).

[79] WHO, *Global Status Report on Alcohol and Health 2014*.

[80] Louisa Degenhart and others, "Toward a global view of alcohol, tobacco, cannabis and cocaine use: findings from the WHO World Mental Health Surveys", *PLOS Medicine*, vol. 5, No. 7 (2008); and European Commission, Netherlands Institute of Mental Health and Addiction and Rand Europe, *A Report on Global Illicit Drugs Markets 1998-2007* (2009).

[81] E/CN.7/2008/CRP.17.

B. Providing appropriate services to address adolescent substance use

99. States should adopt appropriate measures to protect children from illicit drug use and involvement in the illicit drug trade.[82] However, this must be read in the context of the protections afforded by the Convention on the Rights of the Child and other human rights obligations.[83] Almost all States have obligations under the three United Nations drug control conventions, which must be read in conformity with concurrent human rights obligations.[84] The Framework Convention on Tobacco Control contains specific provisions aimed at the protection of children and young people, and which complement the right to health.

100. States should provide prevention, harm reduction and dependence treatment services, without discrimination, and allocate a budget sufficient to the progressive realization of the right to health. These are not competing or alternative strategies but required components of a comprehensive approach to enable adolescents to seek the health services and information they are entitled to receive. All such services should comply with the availability, accessibility, acceptability and quality framework.

101. With regard to the prevention of substance use, children and young people should be provided with accurate and objective information,[85] which should be available in easy-to-understand formats or Braille. Scare tactics and misinformation are known to be ineffective, whereas building resilience and trust while focusing on those demonstrating risk-taking behaviours has delivered promising results. The United Nations Office on Drugs and Crime (UNODC) has produced guidance on drug prevention standards[86] to be used when designing prevention policies and porgrammes.

102. Prevention cannot justify disproportionate infringements of adolescents' rights, including their rights to privacy, bodily integrity and education. States are encouraged to continue to restrict and, when necessary, ban alcohol and tobacco advertising, which has too often targeted young people.

103. Substance dependence treatment must be tailored to the specific needs of adolescents. Adolescents must not lose their participation rights in any circumstance, including because of their substance use or dependence. Adolescents have the right to be heard when expressing opinions on their own health care and to give consent to treatment in accordance with their evolving capacities.[87] Confidential counselling and information must be available without parental consent. All drug detention centres where adolescents are arbitrarily detained and suffer extreme abuses must be closed.

104. There is an alarming lack of HIV-related harm reduction services designed for adolescents who inject drugs, as well as multiple barriers to accessing such services, including age restrictions in law, and absence of data on injecting drug use among children and young people in most countries.[88] Technical guidelines on HIV prevention, treatment

[82] Convention on the Rights of the Child, art. 33.

[83] Damon Barrett and John Tobin, "Article 33: protection of children from narcotic drugs and psychotropic substances", in *A Commentary to the United Nations Convention on the Rights of the Child*, John Tobin and Philip Alston, eds. (Oxford University Press, forthcoming).

[84] See A/65/255, para. 13.

[85] See CRC/C/GUY/CO/2-4, para. 50 (d); CRC/C/ALB/CO/2-4, para. 64 (b); CRC/C/ROM/CO/4, para. 71; CRC/C/SWE/CO/4, para. 49 (a); and CRC/C/BGR/CO/2, para. 50.

[86] https://www.unodc.org/unodc/en/prevention/prevention-standards.html.

[87] Committee on the Rights of the Child general comment No. 15.

[88] Harm Reduction International, *Global State of Harm Reduction 2012* (2012), p. 140.

care and support for young people who inject drugs have been developed,[89] and should form the basis of States' efforts in this regard.

105. The growing international debate and efforts by certain States to seek alternatives to punitive or repressive drug policies, including decriminalization and legal regulation, are welcome.

VII. Conclusions and recommendations

106. Investing in the right to health of adolescents offers huge potential to capitalize on positive investments in early years, while providing the opportunity to ameliorate the impact of negative early experiences and building resilience to mitigate future harm.

107. In their health-related and other policies aimed at investing in adolescents, States should be guided by the principle that adolescence is a period of development towards increasing capacity for independent decision-making. Adolescents need to be protected from violence, exploitation and other adversities, but the nature of those protections and their application must take into account the emerging competencies and evolving capacities acquired throughout adolescence.

108. States should invest in empowering adolescents by respecting their rights and autonomy, recognizing their capacities and investing in their health and resilience. All initiatives to address the physical, mental and sexual health of adolescents should be implemented in compliance with international human rights obligations, taking into account the views of adolescents and adopting evidence-based approaches.

109. Policies and services supporting families are a very important part of the efforts by States to ensure that adolescents thrive and grow up as healthy and responsible adults. These policies should respect and protect the human rights of all individual members of family and should exclude measures that undermine the rights of individual members of the family, including adolescents.

110. The Special Rapporteur would like to link his recommendations with the global call to double investment in adolescence as a major precondition of successfully attaining the 2030 Agenda for Sustainable Development and the Sustainable Development Goals.

111. In this connection, the Special Rapporteur recommends that Governments:

(a) Meet their core obligation to recognize adolescents as rights holders by respecting their evolving capacities and their right to participate in the design, delivery and evaluation of all policies and services affecting their health and well-being;

(b) Remove all legal barriers to health facilities, goods and services, such as consent laws that unduly infringe upon the rights of adolescents to be heard and to be taken seriously and, ultimately, upon their right to make autonomous decisions;

(c) Ensure the quality and timely collection of appropriately disaggregated data to inform public policy, and make the reality and needs of adolescents visible;

(d) Adopt a human rights framework for adolescent health, ensuring that health plans and strategies prioritize a holistic approach addressing underlying and

[89] Http://apps.who.int/iris/bitstream/10665/179865/1/WHO_HIV_2015.10_eng.pdf?ua=1.

social determinants and balancing curative service provision with investment in the resilience and autonomy of adolescents;

(e) Guarantee that health systems are responsive to the whole spectrum of health and psychosocial needs of adolescents, and ensure an integrated, multisectoral approach across social, child protective and education sectors;

(f) Ensure that health services are delivered in such a way as to respect adolescents' rights to privacy and confidentiality, address their different cultural needs and expectations and comply with ethical standards;

(g) Ensure that adolescents' health-care and other service providers, including social workers and educators, do not obstruct access to health facilities, goods and services by addressing discriminatory and stigmatizing attitudes and behaviours through information and awareness-raising campaigns;

(h) Ensure that a core package of health services, including both mental health and sexual and reproductive health services, are accessible to adolescents free of charge, and remove practical barriers presented by user fees with a view to developing a basic basket of services for adolescents as a part of their commitments to universal health coverage;

(i) Protect from interference and harm by non-State actors and third parties, including private service providers, by ensuring that they do not compromise the availability, accessibility, acceptability and quality of health-care and other relevant services, facilities and goods for adolescents;

(j) Protect adolescents from violence and neglect, including in family settings, by, inter alia, upholding their right to confidential services and counselling without parental consent;

(k) Take the measures necessary to support families, including through training and services, to increase the abilities of parents to raise children and adolescents in a competent and confident manner and reinforce skills to manage situations in a non-violent way;

(l) Support national human rights institutions to conduct national assessments or public inquiries into adolescents' right to health.

112. In connection to mental health, the Special Rapporteur recommends that Governments:

(a) In line with target 3.4 of the Sustainable Development Goals, formulate and implement a national adolescent mental health policy enabling the development of a spectrum of preventive and curatives services, in consultation with adolescents, that is sensitive to their rights and needs;

(b) Develop a system of adolescent mental health services that is mainstreamed into the community-based infrastructure of health, education and social welfare sectors;

(c) Design and implement adolescent-friendly psychosocial interventions at the community level in a manner that is ethical and consistent with adolescents' rights and on the basis of available evidence, in order to make such services accessible and acceptable and to avoid institutionalization and the excessive use of psychotropic medications;

(d) Ensure independent monitoring of mental health facilities providing services for adolescents with mental health conditions, including psychosocial and

intellectual disabilities, so that standards set by the Committee on the Rights of Persons with Disabilities are progressively implemented.

113. In connection to sexual and reproductive health rights, the Special Rapporteur recommends that Governments:

(a) In line with target 5.6 of the Sustainable Development Goals, adopt or integrate a comprehensive sexual and reproductive health policy for all adolescents into national strategies and programmes in order to ensure universal access to sexual and reproductive health-care services;

(b) Decriminalize abortion and guarantee all adolescents access to confidential, adolescent-responsive and non-discriminatory sexual and reproductive health information, services and goods, including on family planning, counselling, pre-conception care, maternal care, sexually transmitted infections, diagnosis and treatment, as well as modern forms of contraception, including emergency contraception, and safe abortion and post-abortion services;

(c) Ensure that sexual and reproductive health services are welcoming, adolescent-friendly, non-judgemental and guarantee privacy and confidentiality;

(d) Guarantee the provision of age-appropriate, comprehensive and inclusive sexuality education, based on scientific evidence and human rights, as part of the school curriculum;

(e) Repeal laws criminalizing or otherwise discriminating against individuals on the basis of their sexual orientation or gender identity, and put an end to practices and treatments aimed at changing sexual orientation and gender identity.

114. In connection to substance use and drug control, the Special Rapporteur recommends that Governments:

(a) Close without delay all drug detention centres for adolescents, ensure the provision of prevention, harm reduction and dependence treatment services, without discrimination, and allocate a budget sufficient for the progressive realization of the right to health;

(b) Seek alternatives to punitive or repressive drug control policies, including decriminalization and legal regulation and control, and nurture the international debate on these issues, within which the right to health must remain central;

(c) Use the right to health framework to pursue strategies to prevent drug use among adolescents through evidence-based interventions as well as accurate and objective educational programmes and information campaigns.

United Nations A/HRC/32/32/Add.1

General Assembly

Distr.: General
24 May 2016

Original: English

Human Rights Council
Thirty-second session
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Paraguay*

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, on his visit to Paraguay from 23 September to 6 October 2015. Paraguay has made progress with regard to the realization of the right to health, particularly improving basic health-related indicators and harmonizing the normative framework in line with its international human rights obligations. In order for Paraguay to fully realize the right to health, the Special Rapporteur encourages the Government to address a number of serious challenges mostly connected to the implementation of the existing normative and policy framework and the prevalence of inequalities, discrimination and violence against key population groups, particularly women and girls, children and adolescents, lesbian, gay, bisexual and transgender persons and people living with HIV/AIDS. The Special Rapporteur addresses mental health and the challenges affecting the national health system and makes a number of recommendations in the present report.

* The present report was submitted after the deadline in order to reflect the most recent developments.

GE.16-08255(E)
1608255

Please recycle

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Paraguay**

Contents

		Page
I.	Introduction	3
II.	Right to health in Paraguay	3
	A. Background	3
	B. Legal and institutional framework	4
	C. Structural challenges and a human rights-based approach to health	5
III.	Right to health of key populations and groups	6
	A. Women and girls	6
	B. Children and adolescents	9
	C. Lesbian, gay, bisexual and transgender persons	13
	D. People living with HIV/AIDS	13
	E. Right to mental health: priorities and the way forward	14
	F. National health-care system	17
IV.	Conclusions and recommendations	20

** Circulated in the language of submission and Spanish only.

I. Introduction

1. The Special Rapporteur visited Paraguay from 23 September to 6 October 2015 at the invitation of the Government. The purpose of the mission was to ascertain, in a spirit of dialogue and cooperation, how the country has endeavoured to implement the right to health.

2. During his visit, the Special Rapporteur met with high-ranking government officials from the Ministries of Education and Culture, Foreign Affairs, Justice and Labour, Public Health and Social Welfare, and Women. He also met with high-ranking officials from the National Secretariat for Children and Adolescents, the Technical Planning Secretariat, the Secretariat for Social Action, the Social Security Institute, the National Institute of Indigenous Affairs, the National Preventive Mechanism, and the National Secretary for the Human Rights of Persons with Disabilities. He held meetings with the President of the Supreme Court of Justice and members of Congress. He also met with representatives of civil society, international organizations, development and United Nations partners, academics, legal experts and health professionals.

3. The Special Rapporteur visited several health facilities, family health units and schools in Asunción, including in various deprived neighbourhoods in Itagua, Coronel Oviedo and Ciudad del Este. He also visited the Psychiatric Hospital in Asunción, a prison and one educational detention centre for adolescents in Ciudad del Este.

4. The Special Rapporteur is grateful to the Government of Paraguay for its invitation and full cooperation during his visit. He appreciates the crucial support provided by the Human Rights Adviser of the Office of the United Nations High Commissioner for Human Rights (OHCHR) and her team. He is also grateful for the support provided by the United Nations country team, including by the Pan American Health Organization (PAHO), and by all those who contributed their time and experience.

II. Right to health in Paraguay

A. Background

5. In 1989, Paraguay emerged from over three decades of dictatorship under General Alfredo Stroessner and it is still a young democracy. However, the end of the autocratic regime did not bring political stability. In the following years, the country witnessed the assassination of a vice-president, and the contentious impeachment of the first President from the centre-left Patriotic Alliance for Change over the mishandling of a land eviction during which police officers and peasant farmers were killed.

6. With a population of almost 7 million, Paraguay is a multicultural country of vast natural resources marked by deep inequalities particularly affecting those living in rural areas, indigenous peoples, adolescents and young people, and women and girls. It is a landlocked lower-income country with 22.6 per cent of the population living in poverty and 10.5 per cent living in extreme poverty.[1] Although poverty has been reduced over the past decade, it still affects one in four Paraguayans, while extreme poverty affects one in ten.[2]

[1] Directorate-General of Statistics, Surveys and Censuses, Continuous Household Survey 2014, available in Spanish only.

[2] See www.worldbank.org/en/country/paraguay/overview.

The incidence of poverty and extreme poverty among indigenous communities far exceeds national averages (see A/HRC/30/41/Add.1, para. 49). Social spending per capita in Paraguay is one of the lowest in the region with US$ 147 invested in 2010.[3]

7. The country has made significant improvements in the life expectancy of certain sectors of the population, reduced maternal and child mortality rates over the past decades, and introduced successful vaccination campaigns nationwide. However, while under-five mortality has been halved since the 1990s, maternal mortality rates remain among the highest in the region, accounting for 110 deaths per 100,000 live births in 2013.[4] The main causes are preterm birth complications linked to early pregnancies, complications resulting from unsafe abortions, toxaemia, haemorrhages and sepsis (see DP/FPA/CPD/PRY/7, para. 6).

8. The commercialization of agriculture, population growth and forest clearances have led to a dramatic increase in the number of landless communities in Paraguay. Migration into urban areas and shanty towns from rural regions has burgeoned as a result.

9. The Paraguayan economy is small and open, with an average growth rate of 5 per cent over the past decade.[5] During that time, the country has made significant progress at the macroeconomic level, with strong results in fiscal and monetary aspects with the onset of major social reforms. Recent social reforms include free access to primary health care and secondary education, and the expansion of conditional cash transfer programmes benefiting populations in the most vulnerable situations.

10. The first National Development Plan (2014-2030) was prepared with the aim of eliminating extreme poverty and promoting the income growth of the poorest 40 per cent of the population. It includes a component to improve access to and the quality of social services, including health. The Plan supports a medium-term economic framework emphasizing sustainable fiscal policies, improved tax collection, increased effectiveness of social protection policies and their targeting, and broader financial inclusion.[6]

B. Legal and institutional framework

11. Paraguay is a founding member of the United Nations, a member of the Human Rights Council and has issued a standing invitation to the special procedures of the Council. It has ratified almost all the international human rights treaties. Currently, only the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights and the Optional Protocol to the Convention of the Rights of the Child on a communications procedure are pending ratification.

12. Paraguay has ratified all the regional human rights instruments except the Inter-American Convention against All Forms of Discrimination and Intolerance, and the Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance.

13. The constitutional and normative framework recognizes the right to health and other related rights. The National Constitution of the Republic of Paraguay (1992) provides for the right to health in connection to the rights to life, physical and mental integrity and quality of life in articles 4, 6, 7, 68, 69 and 70. Notably, article 68 establishes the responsibility of the State to protect and promote health as a fundamental right. It also

[3] See www.cadep.org.py/uploads/2015/10/EyS-17.pdf.
[4] See www.who.int/gho/countries/pry.pdf.
[5] See www.worldbank.org/en/country/paraguay/overview.
[6] Ibid.

prohibits discrimination in articles 46 to 48, including the obligation of the State to remove all factors that contribute to discrimination. Article 60 of the Constitution recognizes the right to a life free from violence.

14. There are a number of public policies, programmes and initiatives that stem from that framework, including relevant work on human rights indicators and the right to health, which should be continued.[7] The Government has developed a system to monitor the implementation of the recommendations from human rights mechanisms, which is considered a good practice and is being replicated by other countries.

15. Paraguay is to be commended for the adoption in September 2015 of the Act on the health of indigenous people, which was developed in consultation with indigenous peoples. The Act should now be implemented with predictable and sufficient allocation of human and financial resources. In that connection, the Special Rapporteur was concerned to learn during his visit that the budget of the National Institute of Indigenous Affairs had been more than halved.

16. It is worth noting the existence of a National Plan for Human Rights, a National Plan on Education for Human Rights, and a recently approved National Action Plan for the Rights of Persons with Disabilities. In September 2015, the Act on Public Information Access was adopted as the result of collaborative efforts between the Government and civil society.

17. However, Paraguay is one of the few countries in the region that does not have the necessary normative framework to combat discrimination, which represents a historical debt to Paraguayan society.

18. Another issue of concern is the situation of the Office of the Ombudsperson, which suffers from institutional weakness and does not fully comply with the principles relating to the status of national institutions for the promotion and protection of human rights (the Paris Principles). Moreover, the mandate of the incumbent expired in 2008 and there has been no appointment to date.

C. Structural challenges and a human rights-based approach to health

19. Many of the challenges identified during the visit relate to structural and systemic factors that obstruct progress in many areas, including in the realization of the right to health. The main factors include deep and persistent inequalities associated with, inter alia, a regressive tax structure that does not allow for the necessary public investment. Discrimination is widespread and not properly combated owing to the lack of an appropriate normative and policy framework, and the absence of adequate social and educational programmes.

20. In accordance with Decree No. 19.966/98 on local health decentralization, health competencies have been being devolved to local authorities since the late 1990s. Responsibilities have been transferred to the local level, but the new system has failed to address endemic institutional weaknesses, significant budget constraints and prevailing corruption at different levels.

21. Moreover, the effective implementation of the existing normative framework is often hampered by the lack of an effective human rights-based approach to health, including to public budgets and information. That, combined with a non-inclusive model of

[7] See Red de Derechos Humanos del Poder Ejecutivo, "Indicadores de derechos humanos: el derecho a la salud", 2012.

rapid economic growth, seriously undermines efforts made since the inception of democracy to promote and protect the right to health and related rights.

22. The Special Rapporteur highlights the importance of a human rights-based approach to health. The enjoyment of health and the exercise of human rights and fundamental freedoms are complementary. In order to fully exercise human rights and be able to participate in a State's civil, social, political, cultural and economic life, the enjoyment of the highest attainable standard of physical and mental health is necessary. At the same time, human rights and fundamental freedoms are essential to guarantee genuine physical and mental well-being.[8]

23. A violation of or a failure to respect human rights can adversely affect the physical, mental and social well-being of all people. Therefore, public health legislation, policy and planning can promote and protect basic human rights and freedoms, or, on the contrary, can hinder the exercise of basic rights related to physical and mental well-being.

24. The application of international human rights instruments in the context of the health of key populations and groups in situations of vulnerability is still in its infancy in the Latin American region. As PAHO member States have stressed, it is crucial for health legislation, policy and planning concerning those populations to take into account the existing international norms, especially international and regional standards and technical guidelines.

25. Paraguay has a good opportunity to reinforce the link between health and human rights but it should seize it effectively in order to address many cross-cutting challenges.

III. Right to health of key populations and groups

26. During his visit, the Special Rapporteur observed stark disparities and discrimination regarding the enjoyment of the right to health in Paraguay, and was concerned about retrogressive tendencies undermining previous achievements. The disparities mostly relate to barriers to availability, accessibility, acceptability and quality of health care, as well as the underlying determinants such as poverty, food and nutrition, safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information.

27. The lack of essential services in deprived neighbourhoods and in rural and remote areas of the country disproportionally affects groups in situations of poverty and peasant and indigenous communities. Certain key populations and specific groups face serious challenges in realizing their right to health, including women and girls, children and adolescents, lesbian, gay, bisexual and transgender persons, persons with disabilities and people living with HIV/AIDS.

A. Women and girls

Maternal mortality and morbidity

28. Women and girls face numerous barriers in the enjoyment of their right to health, particularly those from groups in situations of poverty and vulnerability, including indigenous women and those living in rural areas. The total fertility rate in Paraguay in 2013 was 2.9 births per woman, but in rural areas the rate was double the national average.

[8] See www.un.org/disabilities/documents/paho_mh_resolution.pdf.

29. The country faces significant challenges in reducing preventable maternal and neonatal mortality. It continues to be one of the countries with the highest maternal and neonatal mortality rates in the region, with a national average of 110 maternal deaths per 100,000 live births in 2013,[9] but that figure hides stark inequalities between rural and urban areas. The highest rates are found both in the poorest departments (Concepción, San Pedro and Caazapá) and in departments with large populations (Alto Paraná and Central). Also, while metropolitan areas such as Asunción and Central show a rate of 68.6, the Occidental or Chaco regions show rates as high as 135.7.[10] While the number of institutional births has increased, particularly in rural areas, there is still a lack of adequate prenatal care, especially among the poorest sectors of the populations.

30. Positive initiatives to address that include the National Plan for Sexual and Reproductive Health (2014-2018), the national mobilization for reducing maternal and neonatal mortality, and the campaign to reduce preventable maternal and neonatal deaths ("Zero Preventable Deaths").

31. Maternal mortality in Paraguay is mostly the result of preventable causes, mainly during deliveries or post-partum complications, including haemorrhage, post-abortion related complications and toxaemia. A high number of cases are associated with early and teenage pregnancy, many of which affect 10- to 14-year-old girls as a result of sexual abuse and violence. According to available data, teenage pregnancies account for 20 per cent of maternal deaths in the country.[11]

32. The situation is aggravated by an extremely restrictive normative framework for the interruption of pregnancies, which criminalizes abortion in all circumstances except when the life of the woman or girl is at risk (art. 109.4 of the Criminal Code). However, that exception is rarely used. As a result, abortions are performed in clandestine locations, causing grave health complications from which many girls and young women die every year in Paraguay.

33. In addition, women and girls who undergo an abortion, even if they were pregnant as a result of rape or incest, face imprisonment. According to article 352 of the Criminal Code, health professionals can be penalized for performing illegal abortions, with sentences ranging from two to eight years.

34. In an attempt to address that, the Ministry of Health passed resolution No. 146 in March 2012 establishing that health centres have an obligation to admit and assist all women, without discrimination, and to respect their right to privacy. The Ministry published guidelines on humane care for post-abortion patients. During the Special Rapporteur's visit, it was unclear to what degree the guidelines were being followed in the health-care sector. Certainly, more efforts are needed to ensure that health professionals are aware of their obligations to maintain their patients' privacy and integrity, and to ensure adequate emergency treatment for post-abortion patients.

35. The Special Rapporteur was extremely concerned to learn that the mothers of young girls who are pregnant are almost systematically criminalized, facing charges for failing in their duty of care. As a result, pregnant girls are confined to homes, isolated from their families and disconnected from their friends and school environment until they give birth. The State has a duty to protect the girls' rights to liberty, privacy and physical integrity,

[9] See www.who.int/gho/countries/pry.pdf.

[10] United Nations Children's Fund (UNICEF), "Situación del derecho a la salud materna, infantil y adolescente en Paraguay", 2013, p. 9.

[11] Ibid., p. 9.

since they are children. In doing so it must balance the girls' best interest with their evolving capacities and the importance of their family ties.

36. In the view of the Special Rapporteur, the existing legal, policy and institutional framework is failing to protect very young girls who have been victims of sexual abuse and are then forced to continue high-risk pregnancies and motherhoods with long-lasting impacts on their physical and mental health.

37. The Mainumby case, widely reported in the media, is an example of a systemic challenge and a structural problem. The case triggered reactions from international experts, precautionary measures from the Inter-American Commission on Human Rights,[12] and a declaration from the European Parliament.[13] That case is, however, just one of the hundreds of cases of 10- to 14-year-old girls who are victims of sexual violence, and are forced into unwanted pregnancies and motherhoods every year.

38. That is a human rights protection issue and a public health concern that must be addressed without delay through changes in legislation, policies and practices based on scientific evidence and a human rights-based approach. Existing legislation should be reviewed to decriminalize abortion and guarantee the therapeutic interruption of pregnancy through access to services, at the least, when the pregnancy is the result or rape or incest, in cases of fetal impairment, and when the life and the health of the mother is in danger.

39. Evidence shows that criminalizing abortion only leads to clandestine and unsafe practices and exposes women and girls to additional dangers, violence and stigma that negatively affect the full enjoyment of their right to health.

Sexual and reproductive health rights

40. According to reports, about 40 per cent of girls aged between 15 and 19 report having had sexual relations, of which 43 per cent did so before the age of 16. More than half of those relations occurred without any planning, 28 per cent engaged on a voluntary basis and 12 per cent were forced. Early sexual relations are more common in rural areas. Most girls use modern contraceptive methods such as condoms (40 per cent), the contraceptive pill and injectable contraceptives, but some still resort to traditional methods. There are no data about the behaviour of adolescent boys.[14]

41. The Special Rapporteur acknowledges the formulation of national plans and programmes, such as the National Plan for Sexual and Reproductive Health, to ensure coordinated delivery of health-care services to that group of the population. However, in 2008, a bill on sexual and reproductive health was introduced with the aim of recognizing sexual and reproductive health as part of the right to health, but it did not progress owing to strong resistance from religious and conservative sectors of society.

42. During his visit, the Special Rapporteur noted that women and girls faced significant barriers to the full enjoyment of their right to health, particularly their sexual and reproductive health rights.

43. The reproductive health services most needed by girls and young women include access to safe, reliable and good quality contraception, comprehensive maternal health services, safe abortion and treatment for complications from unsafe abortion, and prevention and treatment of sexually transmitted infections and HIV/AIDS (see

[12] See www.oas.org/es/cidh/decisiones/pdf/2015/MC178-15-ES.pdf.

[13] See www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+TA+P8-TA-2015-0230+0+DOC+PDF+V0//EN.

[14] UNICEF, "Situación del derecho a la salud", p. 56.

E/CN.9/2014/4, paras. 68-77). However, the right to health requires more than service provision, and attention should be paid to social determinants such as violence, poverty and discrimination, which are reinforced by patriarchal gender norms and stereotypes.

44. Paraguay faces significant shortcomings in the provision of comprehensive sexual and reproductive information and education for children and adolescents in schools, in families and in other settings. Some families are reticent to address those issues and the media often portrays the issues in a sensationalist way.[15]

45. Evidence and information gathered during his visit led the Special Rapporteur to conclude that violence against women and girls can be considered as an epidemic in Paraguay. Sexual abuse and other forms of violence, including domestic violence, are widespread. The main challenges in addressing violence against women include the fact that it is widely underreported owing to prevailing patriarchal gender norms and associated stigma, and that the scope and enforcement of the existing legal provisions remains unsatisfactory.

46. Proactive measures need to be taken to address violence against women and girls. Violence against women should be seen as a human rights protection issue as well as a public health concern, since it is directly associated with adverse consequences on the physical and mental health of the women and girls who are affected. The Special Rapporteur welcomes the draft law on comprehensive protection for women against all forms of violence, which was passed on first reading in Parliament in December 2015. He trusts it will be adopted and implemented without delay.

47. During his visit, the Special Rapporteur received reports of acts of intimidation and harassment against individuals, non-governmental organizations, human rights defenders and lawyers working on women's rights and gender issues, including violence against women and sexual violence. He expressed his concern about that and underlined that in a democratic and open society, it is not acceptable. Those people are playing a crucial role, working to promote and protect the right to health and other rights; they should be able to do so in a safe and enabling environment.

B. Children and adolescents

48. About one third of the population of Paraguay (32 per cent) is composed of adolescents and children, most of them under 15 years of age.[16] Childhood and adolescence are critical moments in life to strengthen resilience and combat illness and morbidity in later life.

49. Paraguay has made improvements in the reduction of infant and child mortality over the past few years, including by expanding the coverage of child immunization programmes. However, neonatal and adolescent (15-19 years old) mortality represent 43 per cent and 20 per cent of the total number of deaths in the 0-19 age group, respectively.[17] Malnutrition still affects many children, particularly indigenous children among whom the chronic malnutrition rate is 41.7 per cent, compared to the national average of 17.5 per cent (see A/HRC/30/41/Add.1, para. 49).

[15] UNICEF, "Situación del derecho a la salud", p. 10.
[16] See www.who.int/gho/countries/pry.pdf.
[17] UNICEF, "Situación del derecho a la salud", p. 9.

50. Paraguay acceded to the Convention on the Rights of the Child in 1990, but has yet to ratify the Optional Protocol thereto on a communications procedure in order to allow effective access to justice and redress for violations.

51. The Code on Children and Adolescents, established in Act 1680/01 of 2001, is the main legal instrument concerning the right to health of the two groups. The Code guarantees the right to information and provides for sexual and reproductive education for children and adolescents (art. 14). It also establishes the obligation of the State to provide sexual educational services and programmes according to the evolving capacities of the child and his or her cultural and family background. Services for those groups should guarantee confidentiality, free and informed consent, and the holistic development of the children's and adolescents' personalities.

52. The Act against Domestic Violence (1600/00) establishes protection for all persons who suffer physical, psychological or sexual abuse or violence in the domestic environment, including children.

53. The National Policy on Children and Adolescents is the main reference for the implementation of the normative framework, together with the national plan for comprehensive early childhood development, aimed at guaranteeing and promoting the rights of children aged between 0 and 8, the national plan to promote quality of life and health with equity for children (2010-2015) and the national plan to promote quality of life and health with equity for adolescents (2010-2015).

54. Over the past few years, there have been commendable efforts to ensure accountability and transparency in the implementation of public policies, including those targeting children. That has been done through the development of indicators, including health-related indicators, and culminated with the development of the 20 commitments to improve the quantity and efficiency of investment in childhood and adolescence.[18]

55. However, serious threats and barriers remain to children's right to holistic development. Violence against children and adolescents is a prevailing challenge in Paraguay. Six out of ten children suffer from some form of violence in their families.[19] Also, six out of ten deaths of adolescents are the result of external causes such as traffic accidents, homicides and suicides.

56. The way in which the authorities are addressing the health and protection of children and adolescents in vulnerable situations, who are exposed to multiple adversities, is an example of ineffective policies and practices. Shortcomings at different levels of policy formulation and implementation hinder the accomplishment of good practices and the implementation of recommendations made by human rights monitoring bodies, international organizations and other stakeholders. There is a need to address the right to health of children and adolescents in a holistic manner and with a multisectoral approach. That means going beyond medical services and addressing the root causes of violence as well as the social and environmental determinants.

57. In Paraguay, there is a lack of adolescent-friendly health services and confidential counselling, as well as poor access to essential services, in particular for indigenous children and adolescents using drugs and alcohol, including in detention. There is also a lack of sustainable investment in promoting children's holistic development, including their emotional and social development.

[18] See www.unicef.org/paraguay/spanish/20_compromisos_ninez.pdf.

[19] UNICEF, "Situación del derecho a la salud", p. 12.

58. The level of drug use and alcohol consumption among adolescents is alarming in Paraguay. About 18 per cent of adolescents consume some type of drug or substance, most commonly alcohol. One out of four adolescents has consumed alcohol before the age of 14, with on average 40 per cent of adolescents aged 14 to 17 and about 25 per cent of those below 14 years old consuming alcohol.[20] The increasing prevalence of HIV/AIDS among adolescents over the past few years is also a source of concern, with an average of 7 new cases every month. Since 2005, that has mostly affected girls aged between 15 and 19.[21]

59. Furthermore, the high rate of early pregnancy in the country reflects the serious protection gap in children's rights, including their right to physical and mental health and integrity, their right to be free from all forms of violence and their right to receive adequate information and health education. The prevalent approach is to consider sexuality only in connection to reproduction, thus ignoring the fact that sexuality is an intrinsic human activity that has multiple personal and social dimensions.[22]

60. Comprehensive sexual education is not properly integrated in school curricula in Paraguay. Confessional groups and ideas have a strong influence on the school system, in which students are being provided with unscientific and inaccurate information about their health. Related education programmes are often not based on evidence and place strong emphasis on abstinence, rather than providing evidence-based information and education to allow students to make free and informed decisions about their sexuality.

61. That certainly contributes to the high prevalence of unwanted pregnancies among girls and of unsafe abortions, and the high risk of the spread of sexually-transmitted diseases, including HIV/AIDS. Evidence shows that access to comprehensive sexual education has a positive impact on the knowledge and health-related behaviours of adolescents and young people (see E/CN.9/2014/4, para. 68).

62. The Special Rapporteur urges the authorities to implement the National Plan on Human Rights Education at the school level, with emphasis on sexual education and information. The 2010 Pedagogical Framework for Comprehensive Sexual Education was a commendable initiative, but was never implemented. The Framework could serve as inspiration for the development of new measures in that area.

Children deprived of liberty

63. Most adolescents who are deprived of their liberty are in pretrial detention, which is in itself a major problem in Paraguay owing to the excessive resort to detention-based measures in the criminal system. The Ministry of Justice, through the Adolescent Offenders Welfare Service, is responsible for the so-called "educational detention centres".

64. There are seven such centres in the country with a population of about 450 adolescents, boys and girls, 90 per cent of whom are detained without having been convicted. The main issues range from the lack of legal personnel during hearings to impose pretrial measures, the lack of inter-institutional coordination among all the authorities involved and other stakeholders, and the lack of qualified staff, such as community psychologists, social workers, paediatricians, ophthalmologists and psychiatrists.

65. The detention conditions in such centres have been a matter of concern for national and international bodies (see CCPR/C/PRY/CO/3, para. 21), and reportedly include overcrowding, the poor quality of the food provided, insufficient potable water and hygiene

[20] UNICEF, "Situación del derecho a la salud", p. 54.
[21] Ibid., p. 58.
[22] Ibid., p. 62.

products, and the lack of basic medicines, including painkillers, antibiotics and anti-inflammatories. Reports also indicate that adolescents placed in those centres have restricted access to their family members, which can have a detrimental effect on their development and social learning. In addition, there have been serious allegations of ill-treatment inside the centres, including corporal punishment and humiliating treatment

66. The Special Rapporteur visited one educational detention centre in Ciudad del Este where, at the time, about 56 children who had committed mostly minor offences were placed. During his visit, he was able to confirm some of those concerns, in particular the lack of programmes to address key issues such as drug use.

67. All efforts made to improve the situation in those centres are compromised by the fact that the majority of the adolescents there should not be deprived of liberty. Alternative non-custodial measures should be put in place. Punitive measures such as deprivation of liberty are a form of institutional violence and only reinforce the cycle of injustice, exclusion and hopelessness in society. They have a detrimental impact on the enjoyment of the right to health, particularly of children.

Right to health in schools

68. Paraguay has made progress over the past decades with regard to the enrolment of children in schools, but significant disparities remain with regard to the situation of girls, those living in poverty and indigenous children.[23]

69. The Special Rapporteur visited schools in several locations during his visit and found it to be one of the most inspiring parts of his visit. He was able to determine that children, in general, enjoy attending school and most teachers are doing their best, despite inadequate salaries, scarce resources and often poor infrastructure.

70. Schools offer excellent opportunities as spaces in which to promote the health and well-being of children, including through nutrition programmes and the provision of health-related education and evidence-based information. However, in Paraguay those opportunities are not always adequately utilized. The health-related information provided is not always evidence-based and the progress in implementing inclusive education for children with disabilities has been limited. In addition, there are almost no measures in place to address bullying and other forms of violence against children in a systemic way in the school setting.

71. The Special Rapporteur witnessed young mothers attending school with their babies and raised the issue of children who drop out of school, many of them girls owing to early pregnancies.

Children with disabilities

72. Although not directly addressed during the visit, the Special Rapporteur notes with concern the situation of children with disabilities. The National Programme of Comprehensive Care for Children and Adolescents with Disabilities is limited solely to the prevention and early detection of disability characteristic of the medical model, and does not take account of the full range of rights recognized to children with disabilities (see CRPD/C/PRY/1/CO, para. 19).

73. Moreover, the scarcity of resources available for the implementation of a public policy on inclusion of children with disabilities is also a source of concern. The number of children with disabilities enrolled in school is very low and most of them are in special

[23] See www.unicef.org/paraguay/spanish/children_16444.htm.

schools. Moreover, the persistent use of terminology drawn from the medical model of disability when assessing educational standards is also worrying.

C. Lesbian, gay, bisexual and transgender persons

74. The Special Rapporteur was pleased to note that the situation and rights of lesbian, gay, bisexual and transgender persons have become more visible in Paraguay over the past few years. The National Plan on Sexual and Reproductive Health includes non-discrimination on the basis of sexual orientation and gender identity.

75. However, lesbian, gay, bisexual and transgender persons face significant barriers in the full enjoyment of their right to physical and mental health. The barriers are connected to deeply entrenched discriminatory attitudes in society at large, which generate stigma, violence and abuse, including in the health system.

76. The Special Rapporteur received testimonies and evidence that lesbian, gay, bisexual and transgender persons face extreme forms violence on the basis of their sexual orientation and gender identity and expression. The violent deaths of at least 34 transgender persons between 1989 and 2013 are evidence of that.[24] During his visit, the Senate held a debate about the situation of transgender persons, and he met with a number of high-ranking government officials who were aware of the specificities and challenges faced by that group.

77. The situation of lesbian, gay, bisexual and transgender persons living outside the main urban areas, some of whom met with the Special Rapporteur, is of particular concern as they are isolated from the main support networks, live and work in very difficult environments and face violence from the community.

78. Lesbian, gay, bisexual and transgender persons face discrimination and rejection from health-care personnel and a lack of comprehensive health services tailored to their needs, particularly when it comes to access to treatment and services for HIV/AIDS. Moreover, confidentiality is not always guaranteed in the provision of health services.

79. Information gathered during his visit allowed the Special Rapporteur to conclude that many lesbian, gay, bisexual and transgender persons do not use health services for fear of stigma and rejection, which can drive many health issues underground with negative consequences for the health of the persons concerned and that of society at large.

D. People living with HIV/AIDS

80. There are approximately 17,000 persons living with HIV in Paraguay,[25] which represents about 0.25 per cent of the total population. On average, there are three new cases of infection every day. Most of the cases are concentrated in Asunción and the Central department, and the most affected groups are men who have sex with men, and sex workers.

81. The Government has taken effective measures to reduce the spread of HIV/AIDS through an evidence-based approach, including access to free testing, distribution of condoms and free provision of antiretroviral treatment. However, in recent years, Paraguay has seen a surge in HIV/AIDS infections resulting from sexual transmission, increasingly affecting young people and adolescents, mainly women and girls.

[24] See www.panambi.org.py/publicaciones/16.

[25] See www.unaids.org/en/regionscountries/countries/paraguay/.

82. The Constitution enshrines the right to health and public health care (art. 68). Additionally, it establishes the right to equality and the principle of non-discrimination for all persons (arts. 46, 47 and 48). The normative and institutional framework includes the Act on rights, obligations and preventive measures in relation to the effects of HIV/AIDS (No. 3.940) and a National AIDS Control Programme. The Ministry of Public Health and Social Welfare is the authority responsible for those instruments.

83. Articles 8.1 and 8.2 of Act No. 3.940 contain provisions that promote sexual abstinence and mutual fidelity as some of the bases for preventing HIV/AIDS, which implies a strong moralistic approach to law-making that does not comply with human rights standards and is not evidence-based. Those provisions should be removed and the section on prevention should be reviewed accordingly.

84. The real challenge lies in the operationalization of the framework. At the institutional level, the division of responsibilities between the Ministry of Public Health and Social Welfare and the National AIDS Control Programme is not always clear, which undermines the implementation of policies and programmes. The responsibilities are also centralized in an ineffective manner, affecting local capacities to prevent and treat HIV cases in rural areas.[26]

85. Persons living with HIV/AIDS in Paraguay suffer from various forms of public and private discrimination, including arbitrary limitations on access to health services.[27] That is exacerbated by the fact that there are no specific programmes or protocols targeting key populations, such as children and adolescents, lesbian, gay, bisexual and transgender persons, indigenous peoples, persons in detention and persons with disabilities.

86. People living with HIV/AIDS are also exposed to discrimination in educational and workplaces, but there is little information, dialogue or awareness-raising about that, as the Special Rapporteur confirmed during his meetings with relevant authorities.

87. Compulsory HIV testing in the workplace is not authorized, but the Special Rapporteur received reliable reports that it is, nonetheless, common practice. In addition, there are established practices in the health sector in response to financial constraints, such as shared transport services for users in remote locations to access treatment, which violate the right to privacy, and should be reviewed without delay.

88. The National Centre for the Treatment of Addictions cannot cope with the existing demand. It should be extended and should adapt its programmes to the needs of those in the most vulnerable situations, including those with less resources, and children and adolescents.

E. Right to mental health: priorities and the way forward

89. Data from 2011 show the following disability distribution among the population at large: mobility, 26 per cent; mental, 25 per cent; speech, 11 per cent and hearing, 6 per cent. The most frequent types of disability among children under 9 years old are paralysis of some sort and Down syndrome, while most children and adolescents between 10 and 19 years old with disabilities reportedly have intellectual disabilities, paralysis of some sort or

[26] PAHO, *Evaluación para el fortalecimiento de la respuesta del sistema de salud al VIH en Paraguay* (Asunción, 2009), p. 16-18.

[27] Fundación Vencer, *Perspectiva comunitaria sobre estigma y discriminación en personas que viven con VIH y sida en Paraguay* (Asunción, 2010).

Down syndrome. The most frequent causes of disabilities in that age group are complications at birth (64 per cent), accidents (7 per cent) and illness (20 per cent).[28]

90. For a number of years now, about 40 per cent of those attending mental health consultations have been adolescents and young persons. The most common conditions were linked to drug abuse, depression, suicide attempts, anxiety, and behavioural, developmental and personality disorders.[29]

91. Paraguay ratified the Convention on the Rights of Persons with Disabilities in 2008, and has since made significant efforts to harmonize and strengthen its normative, policy and institutional framework. It has, for example, adopted the Inclusive Education Act (No. 5136/13) and the Act on Accessibility of the Physical Environment for Persons with Disabilities (No. 4934/12). Those efforts need to continue in order to bring the existing legal, policy and institutional framework in line with the Convention.

92. The National Plan on the Rights of Persons with Disabilities was adopted shortly after the Special Rapporteur's visit. It could be considered a good practice since it was developed in a participatory manner, involving relevant institutions and civil society organizations.[30]

93. However, during his visit, the Special Rapporteur ascertained that, as health professionals and other stakeholders are not aware of some of the recommendations made by the Committee on the Rights of Persons with Disabilities, the recommendations are not properly implemented.

Mental health policy

94. Paraguay has a history of mental health services closely linked and limited to assisting users of mental health services, including persons with disabilities, through institutionalization in the only public psychiatric hospital in the country, the Psychiatric Hospital in Asunción.

95. Paraguay does not have a specific legal framework to protect and promote the rights of users of mental health services and those with mental health conditions and disabilities in terms of their admission to psychiatric institutions. Neither the Constitution nor disability-related laws or national regulations include due process guarantees for the admission into psychiatric institutions or provisions for periodic reviews of involuntary institutionalization. Article 267 of the Civil Code addresses admission to and treatment in such institutions, referring to admission "subject to guardianship" in "adequate establishments", and "under judicial orders" when either the "person's own security", "the security of third parties" or "his/her recuperation" needs to be ensured.

96. Since the 1970s, there have been important initiatives trying to move away from long-term institutionalization and towards community-based services for users of mental health services and persons with mental health conditions, including developmental and psychosocial disabilities. However, good initiatives have been fragmented and have lacked sustainability and adequate backing with human and financial resources.

97. The issue of institutionalization reached the Inter-American Commission on Human Rights, which granted precautionary measures on behalf of the patients of the Psychiatric Hospital in 2003 and 2008. Paraguay was called to protect the life and physical, mental and moral integrity of the 458 patients, paying particular attention to the situation of women and

[28] UNICEF, "Situación del derecho a la salud", p. 69.
[29] Ibid., p. 54.
[30] See www.ohchr.org/SP/NewsEvents/Pages/DisplayNews.aspx?NewsID=16819&LangID=S.

children. In response, Paraguay started a thorough restructuring of its mental health-care services with the support of the World Health Organization/PAHO, including through the drafting of a mental health bill, which is still under way. In July 2010, the Inter-American Commission on Human Rights lifted its two precautionary measures.

98. The first National Policy on Mental Health was issued in 2002 and was followed by the current one, which covers the period from 2011 to 2020. Its overall goal is to establish a holistic and community-based approach that takes into consideration each individual and promotes mental health through actions that are preventive, healing, educational, rehabilitative, promoting community-based participation, while avoiding stigma, confinement and uprooting.

99. In 2008, the substitute homes scheme was launched as a transitional structure to facilitate services supporting independent living in the community. That was a positive initiative, but it has not been extended, which has led to systemic violations of the rights of users of mental health services, such as the right to live in the community.

100. During his visit to the Psychiatric Hospital and in different meetings on mental health, the Special Rapporteur observed that the mental health-care system remains strongly dependent on the outdated model based on long-term institutionalization and excessive use of biomedical interventions such as psychotropic medication and electroconvulsive therapy. The Hospital is poorly integrated in the community and the general health-care system.

101. All of that points to a lack of political will to shift the approach to mental health services and public investments to the community, based on quality services and the empowerment of users, and on human rights and modern principles of mental health policy. An illustration of that is the plan to construct a new building within the premises of the Psychiatric Hospital, with a budget of 2,500 million guaranies. Such an investment would reinforce the outdated model of specialized psychiatric institutions for long-term care, and would add further barriers to the effective reform of the mental health system. The Special Rapporteur urged the authorities to reconsider that decision and use the opportunity to invest existing and planned resources to expand and reinforce community-oriented services with a human rights-based approach.

Way forward

102. A comprehensive reform of the mental health-care system, based on the principles of non-discrimination and respect for the dignity and all rights of users of mental health services, could be successful in Paraguay. It is of utmost importance to make decisions with regard to two aspects.

103. Firstly, a mental health bill could be considered as an appropriate step but with the necessary precondition that the law is in line with the provisions of the Convention on the Rights of Persons with Disabilities. That also means that the new law should not list numerous exceptions to justify restrictions of the human rights of users of mental health services, in particular those with psychosocial disabilities. It should include measures allowing the empowerment of all stakeholders of mental health services, including users of services, their relatives, and service providers such as health professionals, managers and policymakers. That should pave the way to effectively implement the Convention on the Rights of Persons with Disabilities and thus eradicate the legacy of systemic violations of human rights in psychiatry.

104. Second, public investments should be directed not to support psychiatric hospitals or institutions for long-term care, which should be progressively closed, but to community-oriented mental health services. Those services should be mainstreamed within the general health-care services, substitute homes in the community, and inclusive education of children with developmental and psychosocial disabilities.

105. Paraguay is well placed to move in that direction, particularly as it does not have a high rate of persons in residential institutions and psychiatric hospitals compared with many other countries. However, key stakeholders, including the leadership of professional groups, appear not to be ready to seriously consider a real shift in the provision of mental health services. That is why an effective transition should be undertaken in phases. However, in order for that to succeed, real political commitment and will is needed to encourage, guide and engage all stakeholders in a meaningful public debate on how to ensure the full realization of the right to mental health.

F. National health-care system

106. The normative framework establishing the national health system stems from the Constitution, which enshrines the right to health and related rights in its articles 6, 7, 68, 69, and 70. The Ministry of Public Health and Social Welfare was established in 1936 and by means of public law, though a Decree in 2001. The Ministry is responsible for organizing the health system and services in the country and for promoting the health of the general public.

107. The Health Code was promulgated in 1980 through Act No. 836/80 and contains provisions on mental health (arts. 43-48) and health for sport (arts. 49-54), and promotes community participation in the preservation and improvement of health services (arts. 236-238). However, the Code includes a chapter on the "control of the health of individuals" which establishes compulsory health testing before marriage with the aim of identifying illnesses that could threaten the health of one of the spouses (arts. 61), and the requirement to obtain a premarital medical certificate, without which the marriage will not take place (art. 63). That could have discriminatory implications and could violate the right to privacy and family life.

108. During his visit, the Special Rapporteur learnt that the Health Code is in the process of being reviewed, with the technical assistance of PAHO. He welcomed that and hoped that the Code would be updated and reviewed to address all relevant issues from a human rights perspective.

Priorities for strengthening the health-care system

109. The national health system was established in 1996 through Act No. 1032/96, which defines its purpose and organization, including the coordinating role of the National Health Council. The Council is a public-private inter-institutional coordinating body, with regional and community level subcouncils, which meet regularly and include civil society representatives. In June 2012, there were 224 health councils, 211 local health councils and 13 regional health councils present in 87 per cent of the country's districts.[31]

110. However, the National Health Council has not been effective. It has only been convoked once, in October 2014, and historically has not fulfilled its role as coordinator and evaluator of public policies. During his visit, the Special Rapporteur met with staff of the local health council in Coronel Oviedo and was discouraged to learn that it discharges its mandate by simply ensuring the availability of supplies to the local hospital. He was also discouraged by the evident lack of resources and the council's lack of visibility within the community.

111. Health councils, both at national and municipal levels, should adopt modern public health and human rights-based approaches, including health promotion and prevention at

[31] UNICEF, "Situación del derecho a la salud", p. 85.

the community level. In order to achieve that, health councils should actively involve all stakeholders.

Structure and financing of the national health-care sector

112. The national health system in Paraguay is currently composed of a combination of public, private and mixed subsystems that are fragmented and lack coordination and integration mechanisms. The basic structure comprises a central public health system, which includes the Ministry of Public Health and Social Welfare and military and police health systems. There is also a decentralized public health system that includes the Social Security Institute, which covers people who are in salary-based insurance schemes, the National University of Asunción with the Clinical Hospital, and the Maternal and Infant Clinic. The private sector includes non-governmental organizations and cooperatives, and the lucrative prepaid medical services sector, and the mixed component is represented by the Paraguayan Red Cross.

113. That constellation of different subsystems facilitates the persistence of significant and inefficient asymmetries in resource allocation and coverage.[32] For instance, the Ministry of Health and Social Welfare has to cover almost 80 per cent of the population with a budget of about 2.3 per cent of gross domestic product, while the Social Security Institute covers about 18 per cent of the population with a budget of about 1.3 per cent of gross domestic product.[33] Both the Ministry of Health and the Social Security Institute cover about 95 per cent of the population, while the private sector provides services to about 7.5 per cent of the population.[34]

114. It is reported that the endemic lack of coordination between the different elements of the national health system and the high degree of concentration of services in the capital and the Central department[35] is having a direct impact on the quality of the services provided, multiplying costs, and protracting diagnosis and treatment.

115. Initiatives such as the integrated health services network are commendable efforts to tackle the excessive fragmentation and lack of coordination. However, more should be done, which requires political commitment from the highest levels of governance.

116. Public investment in the national health system in Paraguay is among the lowest in the Americas region. According to data from 2011, total health expenditure was 8.1 per cent of gross domestic product, but general government expenditure on health was only 11.2 per cent of total government expenditure.[36] The budget allocated to the health sector was progressively increased between 2007 and 2011 in the framework of human rights oriented policies, but from 2012 onwards the increase has slowed down. One recurrent problem affecting the national health system is the low level of budgetary execution, that is, actual spending of the allocated budget, which has decreased in the past few years. That could imply a lack of capacity to manage existing allocations and could have had a significant impact on out-of-pocket expenditure for families.

[32] See www.cird.org.py/salud/docs/Paraguay_Health_Service_Delivery.pdf.

[33] Coordinadora por los Derechos Humanos del Paraguay, *Derechos Humanos en Paraguay 2014* (Asunción, 2014), pp. 202-217.

[34] See Red de Derechos Humanos del Poder Ejecutivo, "Indicadores de derechos humanos", pp. 84 and 154.

[35] María Cristina Guillén, "Paraguay: sistemas de salud en Sudamérica: desafíos hacia la integridad y equidad", (Ministerio de Salud Pública y Bienestar Social, 2011), p. 27.

[36] See www.who.int/gho/publications/world_health_statistics/EN_WHS2014_Part3.pdf?ua=1.

117. The main sources of financing for the health system are the public budget, social security, out-of-pocket expenditure to private insurance schemes, employer and company contributions to the Social Security Institute, and external sources, which include international cooperation through multilateral or bilateral sources. Out-of-pocket payments are very high, representing almost 90 per cent of the total private expenditure on health in 2011, and have increased over the past decade, particularly affecting the poorest quintiles of the population.[37] That is a source of concern since the ability to pay should never affect an individual's decision whether to access the necessary health goods and services.

118. One crucial element to be considered is the fact that Paraguay lacks a national tax system based on revenue, with most of the taxes being imposed indirectly, which is by definition an unfair system that does not protect those with fewer resources or those in situations of poverty.

Primary care and universal health coverage

119. Decentralization and a policy of universal comprehensive health care were instituted in 2008 as primary strategies for the National Health Plan, which also included human resources for health as one of the central pillars of the health system.

120. The development of family health units since 2009 is a good example of efforts in the direction of ensuring universal health coverage through the primary care system. It is part of the national strategy to promote quality of life and health with equity and to combat poverty. The family health units are meant to be the gatekeepers of the national health system and their main objectives are to detect ailments and avoid illnesses in a timely fashion, to solve health problems close to where people live, and to promote health and a culture of health prevention at the community level.

121. Currently, there are about 790 family health units in operation, each of them providing services to between 3,500 and 5,000 individuals. It is estimated that, in order for the primary health-care system to have a minimum of coverage at the national level and reach out to the 3.9 million people currently without coverage, it would be necessary to establish about 1,300 family health units.[38]

122. After the initial, promising stage of establishing the units, the Special Rapporteur observed that the network requires more resources and more personnel, and that very few new units have been created over the past two years. In addition, there have been significant gaps in addressing the health needs of key populations such as women and children, indigenous communities, and persons with disabilities.

123. The effective decentralization of health competencies following a human rights-based approach is crucial to reducing inequalities and contributing to social cohesion. It is also a key step towards progressively achieving universal health coverage as part of the Sustainable Development Goals. Therefore, it is of utmost importance to use the current momentum to reinforce the expansion and quality of the network of family health units by increasing the number of units and the number of health personnel available, including health promoters, improving the infrastructure and providing for the needs of key groups and populations.

[37] See www.who.int/gho/publications/world_health_statistics/EN_WHS2014_Part3.pdf?ua=1.

[38] See www.mspbs.gov.py/planificacion/informe-de-monitorero-2012/.

Human resources for health and participation

124. The National Health Policy (2015-2030) includes human resources for health as one of the central pillars of the health system. However, Paraguay has traditionally suffered from poor development of human resources in the health-care sector, resulting in inadequate availability and composition of the health workforce, particularly those required for essential services. For instance, there is an endemic lack of health professionals focused on the needs of adolescents, and the theme is not present in the curriculum of paediatricians. In addition, the health system is not well equipped to provide services to adolescents or to respond to their needs.

125. Although there are reportedly 22.5 health workers per 10,000 population nationally, inequitable geographic distribution of health workers linked to poor infrastructure and limited incentives to work in rural areas has resulted in 70 per cent of health workers concentrated in the area around Asunción, where 30 per cent of the population lives.[39]

126. The active involvement of all key stakeholders in the functioning of the health system, including users of services and the health-care workforce, is crucial to ensure trust, transparency and accountability. Currently, key stakeholders, including professional medical organizations, non-governmental organizations representing civil society, users of health services and their relatives do not feel that they are participating in the process of health policy decision-making.

127. In order to address that, the self-regulation of professional health groups should be promoted and the role of health councils at all levels should be reinforced. The quality of medical education and the education of related professions need to be strengthened so that beyond clinical skills, other knowledge and skills are promoted, including human rights, ethics, health management and communication skills.

IV. Conclusions and recommendations

128. The Special Rapporteur notes the progress made in Paraguay with respect to the right to health. In particular, he notes the significant advances made in health-related indicators and the expansion of primary care. He commends efforts made towards the harmonization of the normative framework and the commitment to bring it into line with the international human rights system and framework.

129. However, during his visit, the Special Rapporteur observed serious challenges to the realization of the right to health connected to the implementation of the existing normative and policy framework, and the prevalence of inequalities, discrimination and violence against key populations, particularly women and girls, children and adolescents, lesbian, gay, bisexual and transgender persons, persons with disabilities and people living with HIV/AIDS.

130. The Special Rapporteur would like to reiterate that the right to health should be promoted and protected not only through access to health-care services, supplies and facilities, which should be available, affordable, appropriate and of good quality. The right to health is also realized through the design and implementation of cross-sectoral programmes that address socioeconomic, cultural and environmental factors. Such policies or programmes should be guided by a human rights-based approach with strong emphasis on the principles of equality and non-discrimination, participation and empowerment, and accountability.

[39] See www.who.int/workforcealliance/countries/pry/en/.

131. **The Special Rapporteur recommends that the State:**

(a) **Ratify the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights and the Optional Protocol to the Convention of the Rights of the Child on a communications procedure, in line with the recommendations made during the universal periodic review in 2016 (see A/HRC/WG.6/24/L.5);**

(b) **Pass the bill on comprehensive protection for women against all forms of violence and adopt without further delay a law against all forms of discrimination;**

(c) **Continue and strengthen cooperation with OHCHR and the United Nations system to ensure that the normative and policy framework is guided by a human rights-based approach, including when it relates to the enjoyment of the right to health;**

(d) **Follow up effectively on the implementation of the National Plan on Human Rights Education and on the work done on human rights indicators, particularly on the right to health, that was carried out previously with the technical assistance of OHCHR;**

(e) **Address neonatal mortality and morbidity, including by using the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age (A/HRC/27/31), which was produced by OHCHR in collaboration with WHO;**

(f) **Address the high rates of early pregnancy, including among very young girls, through changes in legislation, policies and practices based on scientific evidence and a human rights-based approach;**

(g) **Create an enabling environment to ensure that every woman and girl has access to safe abortion and post-abortion care, including by ending criminalization and ensuring access to services, at least when the pregnancy is the result or rape or incest, in cases of fetal impairment, and when the life and the health of the mother is in danger, as well as by providing the information and training necessary to relevant health professionals and key groups of women and girls at risk, and by addressing the stigma associated with seeking abortion services or treatment for post-abortion complications;**[40]

(h) **Ensure that barriers to girls' and women's sexual and reproductive rights are removed, including by providing sexual and reproductive health information, services and goods, in particular comprehensive, age-sensitive and inclusive sex education in schools;**

(i) **Ensure that all acts of intimidation, harassment and violence against individuals, civil society organizations and lawyers working on women's rights and gender issues are properly addressed by publically supporting their work and guaranteeing access to justice, protection and redress for victims;**

(j) **Protect children from all forms of violence, including from intrafamily violence and bullying in schools; make sure that non-custodial measures are widely applied to children in conflict with the law, and find suitable alternatives to detention, always bearing in mind the best interest of the child;**

[40] World Health Organization, "Safe abortion: technical and policy guidance for health systems" (Geneva, 2012).

(k) Promote the well-being and autonomy of children by providing them with conducive environments and services, particularly in the health and education sectors; and by ensuring their meaningful participation in all decisions affecting them, particularly in the areas of sexual and reproductive rights and drug and substance use;

(l) Prohibit violence and any discrimination on the basis of sexual orientation and gender identity and expression in all services, including health, education, employment and access to public services; and prosecute perpetrators of violence against lesbian, gay, bisexual and transgender persons, protect victims, and ensure access to justice and remedies;

(m) Eliminate discriminatory provisions towards people living with HIV/AIDS in the policy and legal framework, such as those contained in Act No. 3.940, and ensure that health services are available, accessible, acceptable and of good quality, including by eliminating practices that may infringe on the right to privacy;

(n) Address new trends in the HIV/AIDS epidemic with adequate policies and comprehensive educational and information campaigns, particularly among adolescents and young people;

(o) Start a gradual comprehensive reform of the mental health-care system based on the principles of non-discrimination, participation and respect for the dignity and all rights of users of mental health services;

(p) Develop a system of user-friendly community-oriented services for children and adults with mental health conditions, including persons with developmental and psychosocial disabilities, and ensure that their rights are respected, promoted and protected;

(q) Progressively close the Psychiatric Hospital in Asunción and move towards an effective integration of mental health services in general health care and community life;

(r) Continue the reform and revision of the Health Code by working closely with PAHO and OHCHR, and remove compulsory health testing as a precondition to marriage;

(s) Strengthen the health-care system and ensure adequate, equitable and sustainable financing for health by increasing national budget allocations for health, and ensure that the health system is funded progressively through universal contributions, based on individuals' and families' ability to pay, and that it foresees exemptions for the poor;

(t) Address the excessive fragmentation of the health-care system with a view to integrating existing elements and decentralizing competencies in an effective manner following a human rights-based approach. In the same vein, reinforce health councils at all levels, and expand family health units, ensuring the quality of the services provided.

United Nations A/HRC/32/32/Add.2

General Assembly

Distr.: General
15 June 2016

Original: English

Human Rights Council
Thirty-second session
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, on the sale of children, child prostitution and child pornography and on contemporary forms of slavery, including its causes and consequences on their joint visit to Nigeria*

Note by the Secretariat

The Secretariat has the honour to transmit the present report, which summarizes the findings of the joint visit to Nigeria of the Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Puras, on the sale of children, child pornography and child prostitution, Maud de Boer-Buquicchio, and on contemporary forms of slavery, including its causes and consequences, Urmila Bhoola. The visit was conducted from 18 to 22 January 2016 at the invitation of the Government. The report contains a comprehensive set of recommendations to the Government and other actors to strengthen their efforts to ensure the full protection and promotion of the rights of women and children affected by the Boko Haram insurgency.

* The present report was submitted after the deadline in order to reflect the most recent developments.

GE.16-09906(E)
1609906

Please recycle

Report of the Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, on the sale of children, child prostitution and child pornography and on contemporary forms of slavery, including its causes and consequences on their joint visit to Nigeria**

Contents

		Page
I.	Introduction	3
II.	Background	3
III.	Legal and institutional framework	5
IV.	Human rights abuses against women and children	8
V.	Responses, programmes and strategies	10
VI.	Gaps and challenges	14
VII.	Conclusions	18
VIII.	Recommendations	19

** Circulated in the language of submission only.

I. Introduction

1. The Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Puras, on the sale of children, child pornography and child prostitution, Maud de Boer-Buquicchio, and on contemporary forms of slavery, including its causes and consequences, Urmila Bhoola, conducted a joint visit to Nigeria from 18 to 22 January 2016 at the invitation of the Government. The aim of the visit was to examine measures taken by the Government and other actors to rehabilitate and reintegrate women and children who escaped or were liberated from Boko Haram captivity. The plight of those women and children is complex, multifaceted and brings into consideration a broad spectrum of human rights considerations. All three Special Rapporteurs identified areas of deep concern in relation to their respective mandates, including serious abuses of the human rights of women and children and violations of international humanitarian law, and constraints in meeting the obligation to protect and fulfil their human rights as explained in the ensuing sections.

2. During the visit, the Special Rapporteurs exchanged views with representatives from the Ministries for Women and Social Affairs, Health, Justice and Foreign Affairs, from the Office of the National Security Adviser, the Nigeria Police Force, the National Emergency Management Agency, the Borno State Emergency Management Agency, the Victims Support Fund and the National Human Rights Commission, and members of the National Assembly. They held meetings with diplomatic representatives of European Union member States, civil society organizations, some of the parents of the abducted girls from Chibok and representatives of relevant United Nations agencies, both in Abuja and Maiduguri. They visited the Dalori, Teachers village and Gubio camps for internally displaced persons in Maiduguri and the Kuje Prison Deradicalization Programme in Abuja.

3. The Special Rapporteurs express their gratitude to the courageous women and children and the representatives from the civil society organizations who graciously and generously shared their experiences. They are also thankful to the Government of Nigeria for its cooperation and openness in discussing issues pertaining to the objectives of their visit. They further extend their most sincere thanks to the United Nations country teams in Abuja and Maiduguri for facilitating the visit, in particular the Human Rights Adviser to the country teams.

4. The Special Rapporteurs offer their findings and recommendations in a spirit of constructive dialogue, which they hope to continue with the various interlocutors with whom they met. They therefore remain available for any further consultation and technical support that could ultimately lead to the successful rehabilitation and reintegration of women and children affected by the Boko Haram insurgency.

II. Background

5. North-east Nigeria, and particularly Borno State, has been the base of the group Jama'atu Ahlis Sunnah Lid'dawa'ati Wal Jihad, more commonly known as Boko Haram (most often translated into English as "western education is forbidden"), which has waged a brutal insurgency that has claimed at least 12,000 lives and displaced millions of people within and beyond the borders of Nigeria since 2009.[1]

[1] See www.unocha.org/nigeria/about-ocha-nigeria/about-crisis.

6. Boko Haram was reportedly founded in 2002, but did not emerge as a significant security threat until the group's leader, Mohammed Yusuf, and a large number of its members were killed by security forces in 2009.[2] Since then, the group has conducted a large number of violent attacks, including suicide bombings, against civilians and civilian and military targets, predominantly in the north-east. The insurgency affects not only Nigeria but the entire Lake Chad region and poses a serious threat to regional peace, stability, development and human rights.

7. While analysis of the root causes of the creation and growth of Boko Haram is beyond the scope of the present report, a brief overview is included below as an indication of the context that underpins the findings of the Special Rapporteurs' and related recommendations.

8. While the causes of radicalization, in particular of women and girls, should be further researched, general causes of youth extremism include misinterpretation of religious teachings, linked to, among others, the proliferation of religious sects and religious preachers often lacking knowledge of the religion in which they claim expertise. Persistent poverty, combined with a lack of positive outlook and the socioeconomic fabric of affected communities, are also contributing factors.[3]

9. While children and young people are recruited through abduction and separation from their families, intimidation and coercion, they have also been enlisted through the use of financial and other incentives.[4] For example, it is reported that young suspects who were released by the military claimed Boko Haram had paid them about $30 each to set schools on fire and spy on soldiers.[5] A 2013 progress report on the Millennium Development Goals indicated that youth unemployment was estimated at 37.7 per cent, placing Nigeria among the countries with the worst youth unemployment record in sub-Saharan Africa. The poverty level remained considerably high, with the most recent nationally representative survey indicating a 62.6 per cent poverty prevalence rate, which translates to over 100 million people living in absolute poverty.[6]

10. The most affected groups are women, children and young people living in northern Nigeria.[7] For example, school non-attendance rates in the north can be as high as 72 per cent compared with less than 3 per cent in the south.

11. At the national level, women are disadvantaged compared with men in terms of both education and earnings. In total, 38 per cent of Nigerian women compared with 21 per cent of men have no education, and girls' enrolment is rated at 20 per cent in the north-east compared with 85 per cent in the south-east and north-west regions.[8]

12. Also at the national level, more than half of women reported having had at least one problem gaining access to health care for themselves; nearly 3 in 10 women have experienced physical violence at least once since the age of 15; and 7 per cent have

---

[2] See H. Persson, *Nigeria–An Overview of Challenges to Peace and Security* (Swedish Defence Research Agency, 2014).

[3] F.C. Onuoha, "Why do youth join Boko Haram?", *Special Report, No. 348* (Washington, D.C., United States Institute of Peace, June 2014).

[4] Watchlist on Children and Armed Conflict, *Who Will Care for Us? Grave Violations against Children in Northeastern Nigeria* (September 2014). Available from http://watchlist.org/wordpress/wp-content/uploads/2111-Watchlist-Nigeria_LR.pdf.

[5] See Onuoha, "Why do youth join Boko Haram?" (footnote 3).

[6] See www.undp.org/content/dam/nigeria/docs/MDGs/UNDP_NG_MDGsReport2013.pdf, chapter 2.2.

[7] See Onuoha, "Why do youth join Boko Haram?" (footnote 3).

[8] Akinola Olojo, "Engendering counter-terrorism in northern Nigeria" (June 2013). Available from http://icct.nl/publication/engendering-counter-terrorism-in-northern-nigeria.

experienced sexual violence. Experience of sexual violence varies by region, with 16 per cent of women in the north-east having experienced some form of sexual violence. Spousal violence is also high, with one in four married women reporting that they have experienced physical, sexual or emotional violence by their husband or partner.[9] Around a quarter of Nigerian women have undergone female genital mutilation, a practice that has a profoundly detrimental impact on the health of women and girls, including their psychological and sexual and reproductive health, and is recognized as a human rights violation.[10]

13. Women and girls marry much younger than men; the average age of marriage is about 18 years for women, 9 years younger than for men. In total, 23 per cent of adolescent women aged 15-19 are already mothers or pregnant with their first child. The rates of young pregnancy and motherhood are highest in the north-west and north-east.[11] The adolescent birth rate is 89 births per 1,000 women, while the total fertility rate is 5.7 children per woman. About 27 per cent of women have a live birth before the age of 18, and about 7 per cent have had a live birth before the age of 15.[12]

14. Overall, women have less control over assets like houses or land and thus are exposed to heightened economic vulnerability. For example, nationally, 18 per cent of women own a house, either alone or jointly, and 15 per cent own land, compared with 40 per cent of men who own a house and 34 per cent who own land.[13]

15. In 2015, the maternal mortality ratio was 814 deaths per 100,000 live births, one of the highest in the world.[14] The north-eastern zone has the highest maternal mortality rate in Nigeria, at 1,549 deaths per 100,000 live births, compared with 165 deaths per 100,000 live births in the south-west.

III. Legal and institutional framework

16. The Special Rapporteurs noted the existence of a comprehensive legal, policy and institutional framework in the country providing a solid basis for responding to the current challenges posed by the Boko Haram insurgency. An overview of that framework is provided below.

International and regional legal framework

17. Nigeria has ratified all of the core international human rights instruments, including the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child and its Optional Protocols on the sale of children, child prostitution and child pornography and on the involvement of children in armed conflict; the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its Optional Protocol; the Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families; the Convention on the Rights of Persons with Disabilities; and the International Convention for the Protection of All Persons from

[9] National Population Commission of Nigeria and ICF International, *Nigeria Demographic and Health Survey 2013* (Abuja and Rockville, Maryland, 2014).

[10] See the fifth periodic report of Nigeria on the implementation of the African Charter on Human and People's Rights in Nigeria, available from www.achpr.org/files/sessions/56th/state-reports/5th-2011-2014/staterep5_nigeria_2013_eng.pdf.

[11] See National Population Commission, *Demographic and Health Survey* (footnote 9).

[12] See the fifth periodic report of Nigeria (footnote 11).

[13] See National Population Commission, *Demographic and Health Survey* (footnote 9).

[14] See http://data.worldbank.org/indicator/SH.STA.MMRT.

Enforced Disappearance. Nigeria is a party to the 1927 Slavery Convention and acceded in 1961 to the 1956 Supplementary Convention on the Abolition of Slavery, the Slave Trade and Institutions and Practices Similar to Slavery. It accepted the individual complaints and the inquiry procedures provided by the optional protocols to the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of Persons with Disabilities. Nigeria also ratified the four Geneva Conventions of 1949, the Protocol additional to the Geneva Conventions of 12 August 1949 and the Rome Statute of the International Criminal Court.

18. At the regional level, Nigeria has ratified the 1981 African Charter on Human and Peoples' Rights, its 2003 Protocol on the Rights of Women in Africa (the Maputo Protocol) and the 1990 African Charter on the Rights and Welfare of the Child. Nigeria also ratified the 1998 Protocol to the African Charter on Human and Peoples' Rights on the Establishment of the African Court on Human and Peoples' Rights and is party to the 2009 African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa (the Kampala Convention) and various instruments of the Economic Community of West African States.

National legal framework

19. The 1999 Constitution safeguards the human rights of all in its chapter 4 and provides for protection against slavery, servitude, forced or compulsory labour. It also provides for the protection of children against any exploitation, moral and material neglect.

20. Nigeria has transposed the Convention on the Rights of the Child into national law through the enactment of the Child Rights Act, 2003, which prohibits, among others, slavery and practices similar to slavery, such as the sale of or trafficking in children, debt bondage, serfdom and forced or compulsory labour for children. The Act guarantees the provision of special protection measures for children in need, including assistance and facilities necessary for education, training, preparation for employment, rehabilitation and recreational opportunities in a manner conducive to achieving their fullest possible social integration and individual development. Furthermore, the Act prohibits the recruitment of children into the armed forces. In terms of the federal structure of Nigeria, national law does not apply unless specifically adopted by state assemblies. Only 22 out of 36 states have enacted the Child Rights Act. Borno, Yobe and Adamawa, the three north-eastern states most affected by the Boko Haram insurgency, have not yet done so. The lack of harmonization between sharia law and civil law is also said to be one of the challenges preventing states' adoption of the Act. It is noteworthy that the Child Rights Act defines a child as someone under the age of 18, while the definition in the State Children and Young Persons Laws applicable in the three north-eastern states is someone under 15.

21. The Violence against Persons (Prohibition) Act, adopted in May 2015, aims at eliminating violence in private and public life. It prohibits all forms of violence, including physical, sexual, psychological and domestic. It criminalizes marital rape, female genital mutilation, forceful ejection from home and harmful widowhood practices. It also prohibits discrimination against persons and provides for protection and remedies for victims and punishment of offenders.

22. The 2015 Administration of Criminal Justice Act is aimed at reforming the overall administration of the criminal justice system by promoting efficient management of criminal justice institutions, ensuring the timely dispensation of justice and protecting the rights and interests of all actors. Addressing corruption is said to have increased the independence of the judiciary. It has been said that prosecution and conviction rates for people found guilty of terrorism and other associated perpetrators of acts of criminal violence may increase given the specific timelines for prosecutions laid down in the Act.

23. The termination of pregnancy is illegal except when performed to save a woman's life. Both the Penal and Criminal Codes specify similar penalties for non-compliance. Yet pregnancy terminations are quite common and, because they are often performed clandestinely or by unskilled providers, most are unsafe.[15]

24. The Gender and Equal Opportunity bill has been on the legislative agenda since 2011. The bill would incorporate into national law certain provisions of the Convention on the Elimination of All Forms of Discrimination against Women and outlaw discrimination on the grounds of gender, age and disability. The bill contains provisions related to temporary special measures, the modification of sociocultural practices, and the prohibition of discrimination on the grounds of marital and socioeconomic status, in political and public life, education, the health sector and employment. It would prohibit violence against women, establish the minimum age of marriage at 18 years, and also establish a gender and equal opportunities commission.

National policy framework

25. The National Priority Agenda for Vulnerable Children (2013-2020) is an eight-year strategic framework operationalizing the commitment of the Government to ensure that all children are free from poverty and discrimination and are given the chance to fully develop their potential. The Agenda is tied to the Nigeria Vision 20: 2020 and draws from a number of national sectoral plans, including the National Strategic Health Development Plan (2010-2019), the National HIV/AIDS Strategic Plan (2010-2015), the National Strategic Plan for the Education Sector (2010-2016) and the Subsidy Reinvestment and Empowerment Programme.

26. In 2013, Nigeria adopted its plan of action for the implementation of Security Council resolution 1325 (2000), with a focus on prevention, participation, protection, promotion and prosecution. Of particular relevance are its stated objectives, which include initiating the process of transitional justice, strengthening the justice system to handle cases of gender-based violence and promoting the legal and economic empowerment of women and girls in conflict and post-conflict communities.

27. The draft national peace policy has also been finalized and is expected to be issued as an executive order in 2016. This policy aims to define the institutional and policy framework to guide the activities and mobilize resources to address conflict prevention and promote peacebuilding in the short, medium and long term, taking into account the national context characterized by diversity and a plurality of ethnic, regional and religious identities.

28. A draft national policy on internally displaced persons was still on the Government's agenda at the time of the visit. This policy provides a framework for preventing and protecting citizens, and in some cases non-citizens, from arbitrary and other forms of internal displacement, meeting their needs during displacement and ensuring their rehabilitation, return, reintegration and resettlement after displacement. The policy, which integrates a human rights-based approach and a gender equality perspective, provides guidance on the provision of humanitarian assistance and the implementation of durable solutions in situations of internal displacement, with specific guidance on the rights of internally displaced children, women and other groups of displaced persons.

[15] A. Bankole and others, "The incidence of abortion in Nigeria", in *International Perspectives on Sexual and Reproductive Health* (December 2015), pp. 170-181.

Institutional framework

29. The executive branch in Nigeria is decentralized. Federal ministries are generally responsible for policy guidance, whereas state ministries in the corresponding areas are responsible for implementation.

30. The Federal Ministry of Women Affairs and Social Development is the lead department charged with promoting the general welfare of women and children.

31. The Federal Ministry of Health aims at formulating and implementing policies and programmes related to health towards strengthening the national health system for an effective, efficient, accessible and affordable delivery of health services.

32. The Office of the National Security Adviser coordinates the work related to countering terrorism and violent extremism.

33. The National Emergency Management Agency is the federal policymaking entity charged with guiding, coordinating and directly implementing humanitarian relief interventions and the rehabilitation of vulnerable groups affected by emergencies. The state emergency management agencies complement the National Agency at the state level.

34. The National Human Rights Commission, established by the National Human Rights Commission Act of 1995, is the institution responsible for protecting and promoting human rights. The Commission has been accredited with "A" status by the International Coordinating Committee of National Human Rights Institutions in accordance with the principles relating to the status of national institutions for the promotion and protection of human rights (the Paris Principles).

IV. Human rights abuses against women and children

35. Boko Haram has conducted brutal and widespread human rights abuses and violations of international humanitarian law against civilians, particularly women and children. In his report prepared pursuant to Human Rights Council resolution S-23/1,[16] the United Nations High Commissioner for Human Rights documented such abuses and violations as including sexual violence, rape and child marriage. Child marriage is a form of forced marriage that places children at high risk of child domestic servitude and forced prostitution and can constitute a contemporary form of slavery. The report also includes documented instances of numerous women and girls forced to give birth or undergo miscarriages in extremely difficult conditions. In addition, the Special Rapporteurs were informed of widespread practices of abductions and abuse of women and children by insurgents, forced marriage of women to their abductors and pregnancy resulting from rape, and the disruption of education and health services. In particular, the stigma and discrimination suffered by women and girls associated with Boko Haram, including those who were abducted, escaped or rescued, was reported.

Abductions and sexual violence

36. Boko Haram has used widespread abductions of girls and boys as a part of its insurgency strategy. While the abduction on 14 April 2014 of 276 school girls from the town of Chibok in Borno State gained international attention, a number of other abductions of women and children have been largely unpublicized, including the abduction in 2015 of 300 primary school children and 100 women from the town of Damasak in Borno State. The total number of abductions remains unknown, but it is estimated that thousands of

[16] See A/HRC/30/67.

women and children have been abducted since 2012.[17] A number of abductees have managed to escape or were rescued, with 1,010 children reportedly rescued as at February 2016. The manner in which those women and children were abducted, the duration of their captivity and the conditions under which they were held are diverse. They all referred to sexual violence and other forms of abuse, including situations of servitude, and many returned pregnant or with babies. The number of those who managed to escape remains unknown.[18]

Use of boys and girls in the insurgency

37. Boko Haram has reportedly recruited and used boys and girls in combat and support roles, such as cooks, porters and look-outs.[19] Girls were also subjected to sexual violence and used as sexual slaves by insurgents, which resulted in many becoming pregnant. Those who have escaped or were rescued reported extreme exploitation and being subjected to multiple human rights abuses. Some boys were forced to attack their own families and communities to demonstrate loyalty to Boko Haram, while girls were forced to marry Boko Haram fighters, clean, cook and carry equipment and weapons. Children were also used as human shields to protect Boko Haram insurgents. Another alarming trend is the growing number of women and girls used as "suicide" bombers in urban centres.[20] For example, in 2015, 21 children were used in suicide attacks, all of them girls, with some as young as 9. This number increased from four girls used as suicide bombers in 2014.[21]

Disruption of education and health services

38. The Special Rapporteurs noted that the education and the health sectors, already weak in the north-eastern region, have been the most affected. Health providers working on family planning and providing lifesaving immunization services, together with teachers, have been killed and kidnapped, with reports of their families being threatened. Hospitals and schools have been burned down and ransacked and a number of schools were still used to house internally displaced persons at the time of the visit. Cold-chain facilities were also destroyed. The violence has disrupted HIV services and efforts to eradicate polio. In addition, displacement has increased the risk of outbreak of diseases like malaria, cholera and measles. The insurgency has also created a climate of fear by threatening and intimidating teachers and students who continued to go to school. This has led to school closures, the flight of teachers and the withdrawal of many students, increasing the number of children with no or little education opportunities.

39. It was reported to the Special Rapporteurs that, in the last quarter of 2015, 547 out of 1,713 public schools in Borno State had been destroyed or damaged as a result of the insurgency. This had reportedly prevented access to education for a large number of schoolchildren. While the Government referred to plans to relocate internally displaced persons from schools, a number of schools were still accommodating them at the time of

[17] International Alert/UNICEF, *"Bad blood": Perceptions of children born of conflict-related sexual violence and women and girls associated with Boko Haram in northeast Nigeria* (Abuja and London, February 2016).

[18] See A/HRC/30/67.

[19] UNICEF, *Missing childhoods: The impact of armed conflict on children in Nigeria and beyond* (New York, April 2015); and M. Bloom and H. Matfess, "Women as symbols and swords in Boko Haram's Terror", in *Prism* (vol. 6, No. 1, 2016).

[20] See Fund For Peace and Nigeria Stability and Reconciliation Programme, "Violence Affecting Women and Girls in Select Nigerian States" (October 2015), available from www.nsrp-nigeria.org/wp-content/uploads/2016/01/VAWG-Monthly-Report-18-October-Final.pdf.

[21] See UNICEF, *Beyond Chibok* (New York, 2016), available from www.unicef.org/infobycountry/files/Beyond_Chibok.pdf

the visit when, out of the 114 governmental schools in Borno State, only 78 were operating. More broadly, it is reported that, between 2009 and 2015, Boko Haram destroyed more than 910 schools and forced 1,500 more to close and killed at least 611 teachers, leaving approximately 1 million children with little or no access to school.[22]

Stigma against women and children born of rape

40. All women and girls who experienced sexual violence during the insurgency face stigmatization. Yet the stigma and rejection from families and communities is greater for those who are perceived to have been associated with Boko Haram, as abductees, those living in Boko Haram controlled areas or those who were compelled and forced to become "wives" of Boko Haram insurgents. These women and girls, often referred to by communities as "Boko Haram wives" or "Sambisa women", are shunned and marginalized, even in camps for internally displaced persons. Many view these women as a direct threat, fearing that they have been indoctrinated.

41. The Special Rapporteurs were made aware of a high level of stigmatization and ostracism of children born to women and girls who were abducted. These children are viewed as the next generation of fighters and often seen responsible for the violence and loss suffered by the communities. Popular beliefs about "bad blood" and witchcraft form the basis of these fears. While communities believe that over time relations could be rebuilt and they may be willing to accept the women and girls, acute fear and suspicion persist of children whose fathers are believed to be Boko Haram insurgents. They described such children as "hyenas among dogs" and held the view that "the child of a snake will always be a snake". While religious and traditional leaders have been reportedly more open towards accepting the mothers and their children, most of the displaced communities remain deeply distrustful of the returnees.[23]

Displacement

42. The insurgency and security responses to counter it have caused massive displacement with just under 2 million persons displaced in the north-east as a result of protracted violence, representing a sharp increase from the figure of approximately 260,000 in 2014. Displacement has had grave consequences on the human rights of those affected, including access to food, water and sanitation facilities and livelihood opportunities inside and out of camps. In addition, camps have not been spared from targeted attacks by Boko Haram leading to an increase in protection gaps.[24]

V. Responses, programmes and strategies

43. Significant interventions managed by different authorities and actors, federal and state, have been implemented in response to the insurgency and the resulting human rights violations. Increasing efforts have been made to ensure the efficient coordination of activities as part of an integrated response, though it is acknowledged that some challenges remain (see section VI).

[22] See Human Rights Watch, "They set the Classrooms on Fire": Attacks on education in north-east Nigeria (2016), available from www.hrw.org/report/2016/04/11/they-set-classrooms-fire/attacks-education-northeast-nigeria.

[23] See International Alert/UNICEF, *"Bad blood"* (footnote 21).

[24] See Refugees International, "Nigeria's Displaced Women and Girls, Field Report" (Washington, D.C., April 2016).

Security responses

44. The Civilian Joint Task Force, an organized local self-defence group, emerged in 2013 to support military counter-insurgency operations to identify and arrest Boko Haram suspects, control security checkpoints, provide information and monitor the movement of people. Local vigilante groups reportedly also operate in other areas. While membership is voluntary and the Task Force pledged that no child under the age of 15 would be allowed to join, a number of children continue to be involved, often owing to peer pressure or out of fear of reprisals, or out of gratitude for increased security in their communities.[25] While the Special Rapporteurs did not interact with the Task Force, they saw their members patrolling roads in Maiduguri and operating in the camps for internally displaced persons.

45. Boko Haram activities have progressively spilled beyond the borders of Nigeria into Cameroon, Chad and the Niger, and the group has established itself as a regional threat, prompting a response by the Africa Union. This regional military response includes the deployment of a multinational joint task force, with a mandate to create a safe and secure environment in the areas affected by Boko Haram activities, in order to reduce violence against civilians and end other abuses, including sexual and gender-based violence, and secure full compliance with international law, including international humanitarian law and the United Nations human rights due diligence policy. That task force is responsible for protecting civilians under immediate threat, camps for internally displaced persons and refugees; providing security for humanitarian workers and other personnel; and searching and liberating all abductees, including the young girls abducted from Chibok. The task force is expected to establish standard operating procedures for the identification of victims, the immediate assistance and referral of victims and family reunification and assistance for those abducted and separated, such as unaccompanied children.

Identification of victims

46. The Special Rapporteurs were unable to gain a clear understanding of the procedures used to screen individuals returning from captivity in order to establish whether they are offenders or victims. This is said to occur when such abductees first make contact with the military in front-line areas. Those suspected of association with Boko Haram are subsequently transferred to military detention facilities in the region. Following further investigation, some are charged with offences under the Anti-Terrorism Act and offered enrolment in the "de-radicalization" programme run by the Government (see para. 49).

47. It is also not entirely clear what happens to those not suspected of being Boko Haram insurgents. Some may be enrolled in another type of de-radicalization programme and some let go, most likely ending up in camps for internally displaced persons or host communities. For example, a group of 307 women and 253 children — including 84 boys and 169 girls, 112 of whom were under 5 — who were mostly encountered during military operations in Sambisa Forest, were brought to one such camp in Adamawa State and subsequently transferred to a military facility run by the Office of the National Security Advisor in Kaduna State where they were enrolled in a de-radicalization programme aimed at supporting them in their rehabilitation, de-stigmatization and reintegration into the communities. The Special Rapporteurs did not see the programme in action as by the time of their visit it had ended for the above group and had not yet started for another intake owing to a lack of funding. It was unclear at that time if the programme was due to resume, presumably leaving a gap in relation to the rehabilitation of women and children freed from Boko Haram as the military operations continued to liberate areas from its control.

[25] See A/HRC/30/67.

48. The shortcomings of the screening procedures and the risk that individuals may be detained for a long time with no apparent reason can also be attested by the number of persons reported to have been released from military custody after being investigated and cleared.[26] While the Special Rapporteurs did not specifically focus on this issue, they underscore that any detention must comply with the international human rights norms and standards governing the deprivation of liberty, including that children should never be detained. They recall that these standards must apply even in times of emergency and in combating violent extremism as indicated in the report of the Secretary-General on the Plan of Action to Prevent Violent Extremism.[27]

Countering violent extremism programme

49. This programme led by the Office of the National Security Adviser has three components. The first, called counter-radicalization, is aimed at creating awareness of the threat of violent extremism at the grass-roots level, including by training religious leaders, women and young people and initiating peace initiatives and interfaith processes. The second is the de-radicalization component, the aim of which is to change the behaviour and mindset of Boko Haram adherents, including through cognitive behaviour and group therapy, religious dialogue, religious counselling and vocational training to acquire a basic level of education and skills. The Special Rapporteurs visited this programme, which was run in the Kuje Detention Centre in Abuja with the support of the European Union, and learned about the literacy classes imparted to the inmates to allow them to read the Koran for themselves and the vocational skills training, including in electrics, that some of the inmates were undertaking. Under this component, national security corridors can be provided for those insurgents who wish to lay down arms.

50. The strategic communications component is the third stream, aimed at countering the extremist narrative through media and public information campaigns that spread messages of national identity, tolerance and community resilience.

Humanitarian response

51. While the Special Rapporteurs were told that at the outset the overall humanitarian response was reportedly slow, fragmented and incapable of meeting the needs of the population affected by the insurgency,[28] they learned of much progress in the management of camps for internally displaced persons and service delivery for displaced persons both in camps and host communities. They commend the courageous national and international humanitarian workers who constantly struggle to provide a drop of support in an ocean of needs.

52. The national and state emergency management agencies are responsible for managing the camps for internally displaced persons with trained personnel, including providing food items, clean drinking water, dignity kits, emergency education and medicines. The National Emergency Management Agency, with international partners, established a displacement tracking matrix programme that creates a comprehensive system to collect and disseminate data on internally displaced persons and train government officers on its use. The total number of such persons captured by the programme as at 31 December 2015 was 2,151,979, of whom 1,818,469 were considered displaced as a result of the Boko Haram insurgency. Borno State has the highest number of persons displaced by the insurgency, followed by Adamawa and Yobe States. In total, 51.77 per cent of the

[26] See Naij, "Army hands over 275 Boko Haram detainees", 12 February 2016.
[27] A/70/674.
[28] See Watchlist on Children and Armed Conflict, *Who Will Care for Us?* (footnote 4).

internally displaced population was female. Children constituted 55.73 per cent, more than half of whom were 5 years old or younger. In total, 92 per cent of internally displaced persons lived in host communities, while 8 per cent lived in camps or camp-like sites. Ninety-four per cent of internally displaced persons expressed the desire to return to their places of origin, and it was observed that some movement of return may have started in some locations between October and December 2015.[29]

53. The insurgency and displacement has resulted in the separation of a large number of children from their parents, guardians, caregivers and families; many children have also become orphans. It is estimated that there were over 20,000 unaccompanied and separated children.[30] Children and their caregivers had to flee their areas of residence losing their homes and safety nets and witnessing the most appalling violence, precipitating psychological and social needs. Child-friendly spaces have been created for children and young people, as have community-based committees in camps for internally displaced persons and communities aimed at ensuring social reintegration and physical rehabilitation of children affected by the crisis. A child protection information management system was set up by the Federal Ministry of Women Affairs and Social Development at the federal and state levels and by various international partners to collate information on children separated and/or affected by the insurgency in the four affected states of Borno, Gombe, Adamawa and Yobe. The database provides a consolidated tracking system for the child protection services available to children in those states.[31] The Government has also piloted a community-based rehabilitation programme for placing children in the foster care of families from the same local government area. This programme also includes children who have been rejected by their communities for affiliation with Boko Haram with the aim of eventually reconciling the children with their families.

54. The National Emergency Management Agency, state agencies and humanitarian actors have also been implementing a range of activities, including strengthening community-based protection systems, providing psychosocial support, strengthening referral pathways and monitoring and reporting. For instance, the United Nations Children's Fund (UNICEF) has supported the provisions of psychosocial assistance to girls and boys and their families. The United Nations Population Fund has supported safe spaces in some camps for psychosocial counselling, dissemination of information on reproductive health, skills development and livelihood support for victims of sexual violence.

55. Access to health care has focused on antenatal health services in the camps for internally displaced persons. Pregnant and nursing women are accommodated in separate sectors of the camps, provided with special diets for them and their babies and dignity kits. The relevant authorities and their partners have also provided medical items to health facilities, deployed mobile clinics, mobile intensive care units and ambulances. They have trained internally displaced persons themselves to operate as health workers, have been mentoring community health workers in the camps and have reinforced health assistance to host communities. The specialized assistance needed by those affected by Boko Haram violence is generally scarce. Maiduguri has, for example, one neuropsychiatric ward at the University Teaching Hospital. In addition, programmes have been run to train primary health workers on how to counsel victims of the insurgency.

56. Programmes for the economic empowerment of displaced persons have also been initiated. For example, training in tailoring and sewing has been provided as have assistance in setting up microbusinesses in camps and sourcing microfinance to establish small

[29] See IOM, Displacement Tracking matrix, Round VII Report, December 2015.
[30] Submission by Save the Children International.
[31] Ibid.

businesses. Peace clubs have been formed to enable young people to develop skills and seek financial and material assistance.

57. It is also reported that birth registration has continued in camps for internally displaced persons, although it is unclear whether all babies born in captivity have had their births registered. This remains to be verified.

Other responses

58. The Government launched a "safe schools initiative", including the transfer of 2,400 students from high-risk areas of the three north-eastern states to 43 federal unity colleges across the country. It also supported schooling in camps for internally displaced persons, mobile classrooms and the rebuilding of damaged schools. This initiative complements the Presidential Initiative for the North-east established to support education of displaced children, rebuilding of houses and bridges, demining of farms and economic development, including the creation of jobs for victims of the insurgency.[32]

59. A victims support fund, which amassed 30 billion Naira from the private sector, has supported programmes aimed at providing economic empowerment, education and psychosocial assistance to the women and children affected by Boko Haram violence. The fund has also contributed to strengthening the capacity of medical facilities, including by giving grants to 14 hospitals for medical equipment. The economic empowerment programme has included training approximately 5,000 women in camps for internally displaced persons in a number of skills, including weaving scarves, producing vegetable oil and tailoring. The fund has also provided loans to associations and grants to women.

60. The Government also established a new social protection plan, supported by the World Bank, aimed at improving the quality of teachers and providing cash transfers to extremely poor families on the condition that they enrol their children in schools.[33]

VI. Gaps and challenges

61. The Special Rapporteurs noted that much progress had been made but that a number of gaps remained in implementing policies and enforcing laws in a manner that addresses human rights violations and has a significant impact for women and children affected by insecurity and violence.

Lack of disaggregated data and monitoring

62. Collection and verification of accurate data on the number and typology of affected women, girls and boys and on the human rights abuses and other violations they have suffered continue to be difficult.

63. Human rights monitoring and documentation have remained insufficient. The National Human Rights Commission, with the support of the United Nations Development Programme and the Office of the United Nations High Commissioner for Refugees, has deployed about 314 personnel to the north-eastern and north-central areas to monitor and report on the human rights situation and protection of internally displaced persons. The monitors collect information from the ground, which is then analysed at the headquarters of the Commission. Yet the capacity of the monitors to adequately collect information and

[32] For further information, see www.nationalplanning.gov.ng/index.php/news-media/news/current-news/334-insurgency-fg-development-partners-advocate-multi-donor-trust-fund-for-north-east-region.

[33] See Human Rights Watch, "They set the Classrooms on Fire" (footnote XX).

report on human rights violations and protection of civilians is a concern, as capacity-building is needed to ensure that they have the necessary skills to perform their roles in such a complex setting. Human rights and protection monitoring, where it was carried out, has proved important to map profiles of vulnerabilities, including unaccompanied, separated or orphaned children, child-headed households, cases of rape, sexual assault, forced marriage, so-called "survival sex", which involves the exchange of sex for money for food, single elderly persons with no family or neglected by caregivers, elderly-headed household, serious medical conditions, or people with mental, intellectual and physical disabilities.[34] These profiles should serve to inform tailored and targeted responses. Also, the mapping should cover all the vulnerabilities experienced by the displaced population.

Coordination

64. The Special Rapporteurs received information about the various government, United Nations and non-governmental organizations actors who have been working to address violence against women and children in the context of the Boko Haram insurgency, despite extremely challenging circumstances. While the commitment and investment of all these actors is laudable, concerns have been expressed about fragmented action and lack of adequate follow up. Notwithstanding the coordination mechanisms for protection against sexual violence and for child protection established at the federal and state levels, there is a continued need to further streamline and efficiently coordinate such responses so that all relevant stakeholders, including the United Nations agencies, can maximize their value added and complement more efficiently the response of the Government to the crisis.

Continuing lack of security and safety

65. At the time of the visit, state authorities indicated that all territories except two local government areas had been liberated from Boko Haram control, yet efforts towards rehabilitation continued to be hindered by the lack of physical access to affected women and children due to, inter alia, widespread insecurity, related to, for example, anti-personnel mines, poor infrastructure and ongoing attacks by the Boko Haram insurgents, including in so-called liberated areas. Due to the highly volatile situation in the north-east, access to a number of areas was still restricted to United Nations agencies and international organizations with the consequence that those with the most acute need of protection and humanitarian assistance were not being reached. Furthermore, the very nature of the displacement with many displaced women and children residing among the host communities made it more difficult to access those affected.

66. The Special Rapporteurs were informed that, in camps and host communities, women and girls continued to face sexual violence, with reports of rape, child and forced marriage and survival sex. Overcrowding in camps, with limited privacy, especially toilet facilities and socioeconomic opportunities, exacerbated the risk of sexual violence. While the report of the ad hoc national fact-finding committee established following allegations of rape and child trafficking in camps for internally displaced persons in the north-east found no evidence of child trafficking, adolescent girls have been reported to engage in survival sex to meet their basic needs and support their families.[35] The fact-finding committee also identified risk factors for human trafficking and other forms of exploitation as children go out of the camps unaccompanied to "hawk, beg, fetch firewood or engage in menial labour to earn a living…some also go out at night to socialize…or some are expelled from the camps after having committed offences". The committee also established that there had

[34] See Nigeria Red Cross and others, "North-East Nigeria: Protection Monitoring Report" (December 2015).

[35] See S/2016/361.

been cases of sexual molestation, exploitation and defilement in the camps as officials took advantage of the vulnerabilities of internally displaced persons, protected by a "conspiracy of silence". Reference to allegations of rape of internally displaced girls living in camps by security personnel was also made in the community charters of needs agreed upon by the internally displaced communities of Bama, Chibok, Gwoza and Konduga.

67. Notwithstanding the security imperative, the Special Rapporteurs recall that counter-insurgency measures must be taken in full compliance with international human rights and humanitarian law.

Gaps in implementing comprehensive rehabilitation and reintegration programmes

68. Rehabilitation and reintegration programmes must include the full range of policies and services that are necessary to ensure the physical, cognitive, psychological, psychosocial and spiritual recovery, and the full social reintegration, of victims.[36] Such programmes must also go hand in hand with measures to enable victims to seek redress.

Access to health

69. During their visits to camps for internally displaced persons in Maiduguri, the Special Rapporteurs witnessed first-hand the health and social impacts of the insurgency and the remaining gaps in these sectors. They met with women and girls who reported limited access to services, including adequate nutritious food, psychosocial support, education and health, including sexual and reproductive health services. Internally displaced persons have also reported lack of proper care for pregnant women and lack of medical attention for nursing mothers.

70. The Special Rapporteurs received reports of women and children who had been brought to some camps but not given adequate shelter or provided with sufficient drinking water for more than eight days. They also heard a number of comments indicating a worrying perception among government officials both at the national and state levels that internally displaced persons living in the camps are better off than those living in host communities, or even the host communities themselves.

Psychosocial support

71. Concerning the provision of psychosocial counselling, the number of those in need outstripped the services available particularly in view of those still missing who hopefully will return shortly.

72. The International Organization for Migration (IOM) conducted an assessment[37] of psychosocial needs in some camps in Yola, which found that internally displaced persons feel uncertain about the future owing to separation from families, and at loss owing to a loss of identity, status and assets. Factors provoking these feelings included displacement and separation from families, lack of freedom, loss of lives and property, lack of basic and social amenities, lack of jobs or income-generating activities, maltreatment by security personnel and issues of availability, quantity, quality and distribution of food. The willingness to go home but uncertainty associated with the return or lack of means to return played a substantial role in determining those feelings. The assessment confirmed the presence of people with mental disorders in the camps and host communities. The disorders

[36] See A/70/222.

[37] IOM, "An Assessment of Psychosocial Needs and Resources in Yola IDP Camps: North-East Nigeria" (Geneva, June 2015).

probably pre-existed displacement and risk being unacknowledged because of the needs of the mainstream displaced population and the shortage of specialized health providers.

Lack of livelihood opportunities

73. The lack of livelihood opportunities for women inside camps for internally displaced persons and in host communities, especially those who are rejected and separated from their families and communities, has also contributed to creating destitution, feeling of helplessness and heightened risks of exploitation and abuse.

74. Outside of the camps, internally displaced persons are hosted by low-income communities thus bringing already stretched services and resources under increased pressure. As a result, negative coping strategies and risky livelihoods have been recorded, such as begging and child labour. In addition, there is a gap in the interventions targeting host communities and the displaced persons they have hosted.

Lack of effective monitoring and follow-up

75. Another glaring challenge is the lack of follow-up in relation to rehabilitation and reintegration assistance, which may become particularly worrying as women and children return to their places of residence. For example, no details were available on the whereabouts of and follow up support to the 307 women and children who underwent the programme of the Office of the National Security Advisor in Kaduna, apart from 8 unaccompanied children whom UNICEF was supporting with the Ministry of Women Affairs and Social Development.

76. The case of the Chibok girls, whose whereabouts continue to be unknown two years after their abductions, remains a living illustration of the failure of some of the responses. Yet the abducted schoolgirls have not been forgotten and their rescue is very important not only to their families but also to the whole Chibok community, which believes that their rescue will help in healing the emotional wounds. The girls' parents, some of whom the Special Rapporteurs met with during the visit, are desperate for information on the steps taken by the Government to locate and liberate them. Yet when asked by the Special Rapporteurs, the authorities claimed that such information cannot be disclosed for security reasons. The Special Rapporteurs are mindful of such constraints but believe it would be important for the parents to have a regular and accessible interlocutor who could keep them informed and relay their grievances to the various governmental agencies. The parents are also in need of support to cope with their suffering; some have died following the abduction and some have been living with deep trauma.

Stigma

77. As discussed above, women and children who have been abducted and their children born of rape have faced significant stigma and social exclusion upon return to their communities.[38]

78. The Special Rapporteurs are mindful of the corrosive effect that stigma can have, not only on the rehabilitation and reintegration of women and children, but also on their future vulnerability to violence and exploitation. Their abduction and abuse by Boko Haram and subsequent social exclusion can create extreme vulnerability to violence and exploitation, including many forms of contemporary servitude, such as labour and sexual exploitation, forced marriage, forced labour and the worst forms of child labour. Effectively

[38] See International Alert/UNICEF, *"Bad blood"* (footnote 21).

tackling this stigma within broader efforts to increase rehabilitation and reintegration is crucial to preventing further such violence.

79. In this regard, the Special Rapporteurs encourage the authorities and all service providers to build on lessons that have been drawn from similar experiences in other countries and that point to the fact that the issue of children born of war can become a "time bomb".[39]

Access to justice and remedy

80. There appears to be a significant gap in current responses in terms of accountability for crimes perpetrated in the context of the insurgency. The Special Rapporteurs were informed that there had been very few prosecutions of insurgents. The national authorities have undertaken a number of investigations, namely, the Presidential Committee on security challenges in the north-east in 2011, and the Presidential Committee on dialogue and peaceful resolution of conflicts in 2013, as well as other investigations conducted by the military, but the outcome of these initiatives remains unknown.

81. Access to remedies for victims of the insurgency, including of sexual and gender-based violence, is almost non-existent for a range of interrelated and mutually reinforcing factors, including resistance to reporting for fear of stigma, ostracism and reprisals, ignorance of entitlements and avenues to claim them, mistrust of authorities, a context of entrenched discrimination and stereotypes, and lack of training and sensitivity of public officials, including law enforcement officers, among others. The Special Rapporteurs were informed of some non-governmental organizations providing legal aid to women and girls to get their marriages annulled under sharia law, which should be highlighted as the kind of support paving the way for sustainable and empowering rehabilitation efforts.

82. Owing to stigma and discrimination and fear thereof, many women and girls are reluctant to talk about their experiences and therefore may not be willing to seek remedies and access the related services. They may not know how to report sexual violence or may not trust formal authorities. The lack of information on available options for women and girls remains a major gap.[40]

VII. Conclusions

83. The Special Rapporteurs have noted the efforts made by the Government and other actors to face the challenges posed by the Boko Haram insurgency. They acknowledge that the Government has taken commendable steps to meet its obligations to protect individuals within its jurisdiction from human rights abuses and violations of international humanitarian law committed by non-state actors. Yet the extent of those challenges and the numbers of people in need remain overwhelming and unfortunately stretches well beyond the reach of current programmes. This unmet need is particularly high considering that recent challenges have exacerbated important pre-existing problems affecting the population in Nigeria and the Lake Chad region.

[39] There are particular lessons to be drawn from Uganda. See, for example, Justice and Reconciliation Project, "We Are All the Same: Experiences of children born into LRA captivity", Field Note 23 (December 2015); International Center for Transitional Justice, "From Rejection to Redress: Overcoming Legacies of Conflict-Related Sexual Violence in Northern Uganda" (Kampala, October 2015); and V. Ladisch and L. McClain, "For children born of war, what future?" (12 June 2015), available from www.opendemocracy.net/opensecurity/for-children-born-of-war-what-future.

[40] See International Alert/UNICEF, *"Bad blood"* (footnote 21).

84. The Special Rapporteurs therefore believe that it is important not only to ensure that rehabilitation and reintegration measures are grounded in human rights norms but also that they aim to fundamentally transform society for the better while addressing the immediate needs of women and children. These measures must also address root causes, especially poverty, discrimination, lack of security and deprivation, stigma, exclusion and gender inequality, as the insurgency and subsequent military responses have taken place against a backdrop characterized by inequalities among regions with the north-east faring less well than other regions of the country and among different groups of the population with women and children already marginalized in many sectors. The Government must seek to address the underlying causes of disparities in the north-east vis-à-vis other regions considering the parity of resource allocation from the centre.

85. In line with the human rights-based approach, the development of policies, frameworks and other measures must be participatory, based on consultations with the affected population and aim at promoting agency, hope, aspirations and a positive outlook for the future.[41] In addition, these measures must be well resourced, implemented by trained staff and backed by political will in order to avoid the fate of previous initiatives aimed at addressing inequality.

86. Only the implementation of a comprehensive, holistic and integrated approach to addressing the challenges in the north-east will provide a good opportunity not only to reintegrate women and children affected by Boko Haram but also to strengthen the institutional system, particularly the health and educational sectors, which are crucial for peace, security and sustainable development in Nigeria.

87. Effective reintegration and rehabilitation efforts must include from the outset measures for restorative justice and effective redress for survivors and to be sustainable must also be accompanied by economic growth. Social cohesion, integration and national unity can only be nurtured by a holistic approach that heals, repairs, protects, empowers and transforms.

88. The Special Rapporteurs also underscore that a comprehensive approach should take into account the persisting emergency and relief needs at the same time as addressing the emerging needs related to return and recovery. There is a risk that, because of the prevailing insecurity in certain areas and no real prospect of receiving rehabilitation and reintegration support, returnees may end up being displaced multiple times, including beyond national borders. Hence the importance of setting up mechanisms for promoting safe, dignified and voluntary return. National and state authorities should work to enhance cooperation with relevant humanitarian agencies to achieve these goals.

VIII. Recommendations

89. On the basis of the above considerations, the Special Rapporteurs would like to offer the recommendations below to the Government to be implemented in cooperation with its international and regional partners.

[41] See A/70/222, para. 81.

90. **Concerning the legal, policy and institutional framework, the Government should:**

(a) **Ensure the Child Rights Act and the Violence against Persons Prohibition Act are adopted in those States that have not yet done so and enforce those Acts;**

(b) **Adopt and implement the draft national policy on internally displaced persons and the draft national peace policy;**

(c) **Review and amend the legislation criminalizing termination of pregnancy;**

(d) **Adopt the Gender and Equal Opportunity bill and ensure its effective implementation at all levels of government;**

(e) **Work with the states within Nigeria in order to sensitize them to their responsibilities under international human rights law.**

91. **Concerning data collection, analysis and monitoring, the Government should:**

(a) **Invest in the collection of disaggregated data and documentation to understand the scale of violence, including sexual violence, in particular to capture the experiences of women and children taking into account the best interest of the child and key principles of informed consent, confidentiality and referral;**

(b) **Scale up human rights monitoring and documentation by first and foremost strengthening the capacity of the national actors and entities involved in such monitoring, including the National Human Rights Commission and the National Committee against Torture. This should be complemented by an enhanced human rights advisory capacity within the Office of the Resident Coordinator and country team taking into consideration the existing monitoring and reporting mechanism under the mandate on children affected by armed conflict. The documentation generated from the monitoring should be shared with and analysed by relevant actors to inform policies and programmes; the country team should work hand in hand with national actors to ensure that the monitoring and reporting mechanisms in place are linked to accountability mechanisms;**

(c) **Ensure follow-up mechanisms, such as rehabilitation and reintegration measures, include long-term actions, particularly as individuals start returning to their places of habitual residence;**

(d) **Set up a tracking system for missing persons, whether abducted or detained, and provide information to the families; and set up a tracking system to reunite unaccompanied and separated children with their families and communities, taking into consideration the best interest of the child;**

(e) **In the light of the political will expressed at the highest level, step up efforts to locate the Chibok girls and all other abducted civilians, bring the perpetrators to justice and designate a focal point to channel information to the girls' parents.**

92. **Concerning identification, the Government should:**

(a) **Establish clear, transparent and predictable procedures for screening those liberated from Boko Haram-controlled areas and inform all key stakeholders about such procedures;**

(b) **Allow relevant governmental and non-governmental agencies, including the National Human Rights Commission, to monitor the implementation of such**

screening procedures and ensure effective avenues for reviewing outcomes where relevant;

(c) Integrate a gender-based perspective in de-radicalization programmes and adapt such programmes to women and girls;

(d) Ensure that all the necessary measures are taken during screening procedures to prevent the separation of children from their families and in cases where this may accidentally happen ensure with due diligence that unaccompanied and separated children are reunited with their families.

Comprehensive recovery and reintegration

93. Concerning security, the Government should:

(a) Provide and maintain the highest possible level of security for victims, including securing access to the most remote and insecure areas so as not to leave behind anyone who may be in need of assistance;

(b) Improve coordination between military and humanitarian actors while maintaining the independence and neutrality of humanitarian work.

94. Concerning health, the Government should:

(a) Strengthen health systems so as to meet the physical and mental health needs of both the displaced and the host communities, in particular those of girls and women victims of sexual violence;

(b) Ensure that survivors of sexual violence who seek assistance have access to comprehensive clinical services, including emergency contraception and post-exposure prophylaxis to prevent HIV infection, and authorization from the authorities for termination of pregnancy for those wishing to do so;

95. Concerning education, the Government should:

(a) Promote the reintegration of pregnant girls and girls with young children into schools and build teachers' capacity to meet the needs of those girls;

(b) Ensure that all school sites are reopened promptly and all children, in particular girls, are able to access free and quality primary education without fear;

(c) Accelerate the rebuilding of damaged schools;

(d) Increase the provision of education in camps for internally displaced persons;

(e) Ensure that children born of rape are not stigmatized and have equal access to vocational training, life skills and socioeconomic support, sports and leisure activities, religion and cultural practices by means of an individualized plan that is adapted to the child's needs.

96. Concerning stigma, the Government should:

(a) Sensitize all actors involved, including governmental and non-governmental organizations, about the vulnerabilities and risks faced by women and children born of sexual violence;

(b) Work with communities to prepare the return and acceptance of these survivors, dispelling bias and stereotypes towards these women and children; engage traditional and religious leaders in these efforts; and use the media to raise awareness of the situation of these women and children;

(c) Establish peer support groups and platforms to enable women and children to share their experiences and provide mothers with parenting skills.

97. Concerning social and other support, the Government should:

(a) Promote the expansion of community-based programmes to support the care, rehabilitation and reintegration of girls and women who were abducted and who may have experienced sexual violence. These programmes should include psychosocial support and counselling, including to families. The right to privacy of the women and girls who escaped from Boko Haram and wish to be protected from public exposure should be respected;

(b) Ensure that child victims have access to safe and secure housing, create emergency and longer-term alternative care placements for the children unable to remain with their mothers or communities in accordance with the best interest of the child and the Guidelines for the Alternative Care of Children;

(c) Invest in the development of safe spaces to promote the dialogue between different stakeholders that is necessary for rehabilitation;

(d) Fund income-generation skills training, skills development and livelihood opportunities so that women can catch up on the education they missed and ensure their economic empowerment, access to decent work and independence from their families and communities. This will go a long way in ensuring internally displaced persons have the necessary skills and the opportunities to build normal lives and integrate in their former or new communities;

(e) Ensure birth registration for all children and identification documents for all displaced persons;

(f) Strive for the full realization of the rights of children born following sexual violence through, among others, the provision of educational scholarships and assistance to organizations supporting these children with psychosocial counselling, educational facilities, peer support centres and diverse vocational training;

(g) Empower child victims through child-sensitive procedures and accessible avenues for participation that foster a sense of agency in their care, recovery and reintegration programme, keep them informed and allow them to be consulted on decisions affecting them.

98. Concerning access to justice and remedies, the Government should:

(a) Secure accountability and address impunity for all forms of violence against women and children, including sexual violence and exploitation, sexual slavery, domestic servitude, child and forced marriage, recruitment and use of children in the insurgency and other slavery-like practices;

(b) Investigate the crimes committed by Boko Haram and prosecute and punish all those responsible in order to fight impunity for violations of human rights and international humanitarian law;

(c) Ensure that women and children have access to just and effective remedies, as this is paramount to their recovery and reintegration;

(d) Build the capacity of the law enforcement services to investigate and prosecute cases of violence against women and children;

(e) Ensure access to legal counsel for those women and children who wish to seek redress through the justice system;

(f) **Ensure the establishment of child-friendly reporting and complaint mechanisms;**

(g) **Set up witness and victim protection services for all women and children affected by violence;**

(h) **Promote legal aid and dispute settlement opportunities for the most vulnerable, including internally displaced persons and returnees;**

(i) **Develop transitional justice plans and mechanisms, in accordance with the national plan of action on Security Council resolution 1325 (2000), aimed at community cohesion, peacebuilding and reconciliation as people begin to return from displacement;**

(j) **As part of transitional justice plans, disarm, demobilize and reintegrate children and young men members of the Civilian Joint Task Force;**

(k) **Ensure the respect of the human rights of civilians associated with Boko Haram who have left or been released, especially children.**

99. **In addition, the Special Rapporteurs recommend that the United Nations, international organizations and bilateral partners:**

(a) **Continue to support the Government in addressing the challenges caused by the Boko Haram insurgency, ensuring a clear focus on effective rehabilitation and reintegration of women and children affected by violence in compliance with international human rights law and standards;**

(b) **Within such efforts, promote effective coordination between different agencies and organizations, including between humanitarian, human rights actors and development agencies;**

(c) **Building on existing tools, continue to support the Government in developing effective data collection and protection monitoring systems and strengthening synergy among the complementary mechanisms;**

(d) **Contribute to mobilizing support to promote economic growth, particularly in the north-eastern region;**

(e) **Provide increased funding to address the remaining gap in funding shortfalls for humanitarian and recovery programmes.**